WD PLAN
GROUP AND INDIVIDUAL

Western WD Dental®

PROVIDER GUIDE

2024

Western Dental Services, Inc.
530 South Main Street
P.O. Box 14227
Orange, CA 92863
1-800-811-5111
1-800-992-3366

PROVIDER GUIDE

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SECTION

I.

INTRODUCTION

“Welcome!”

Western Dental® & Orthodontics

HOW TO REACH US

Eligibility/Member Services 1-800-992-3366

Our bi-lingual representatives welcome opportunities to assist your dental office with any questions you may have regarding eligibility and plan benefits.

Additional interpretative services are available to our providers and plan members and are arranged by calling Member Services. They are available to assist you Monday through Friday from 8:30 a.m. to 5:00 p.m.

Should an emergency arise after office hours, call our after-hours toll-free number **(800) 522-0056** seven days a week for assistance.

Claims 1-800-992-3366

The claims department staff is available to assist you with your lab reimbursement, specialty and emergency referral claims.

Claims should be mailed to:

Western Dental Services
Attn: Claims Department
P.O. Box 14227
Orange, CA 92863

Provider Relations 1-800-811-5111

We are available to answer questions regarding necessary paperwork to add associates or specialists to your office, capitation payments, payment summaries, and eligibility rosters. You may also call us for all of your form needs (encounter data, specialty referrals and guaranteed capitation).

To write to Provider Relations:

Western Dental Services
Attn: Provider Relations
P.O. Box 14227
Orange, CA 92863

Patient Relations 1-800-992-3366

Western Dental encourages members and providers to attempt to resolve issues when there is a problem. Patient Relations Staff is available to assist your office staff and/or your Western Dental patients with issues or problems that cannot be solved in your office.

To write to Patient Relations:

Western Dental Services
Attn: Patient Relations
P.O. Box 14227
Orange, CA 92863

ABOUT OUR COMPANY

Western Dental Services, Inc. (WDS) is licensed under the California Knox-Keene Act of 1975. WDS opened its door as a Dental Health Maintenance Organization (DHMO) in 1985 to meet the increased demand for dental care in a changing economic environment. We offer a structured and effective way to help reduce the high cost of healthcare while improving quality and increasing accessibility.

Our goal is to bring dentists and patients together, provide high quality dental care to groups and individuals by offering a flexible set of benefits that are advantageous to our members and providers.

II.

ELIGIBILITY

ELIGIBILITY

The following section contains important information about how to verify patient eligibility as well as how to identify a Western Dental plan member.

ELIGIBILITY VERIFICATION

On or before the tenth day of each month, WDS will notify each provider, in writing, of the names of the subscribers who are eligible for dental care in their office for that month.

If someone is seeking care at your office and you CANNOT verify or find the member's name on your roster, BEFORE rendering services you should:

Call our Member Services Department at **1-800-992-3366** to verify Eligibility *(please remember to get the name of the representative you spoke to).*

If the member does not have an I.D. Card and is not listed on your eligibility roster, call the Member Services Department BEFORE rendering services. Our staff will verify eligibility or advise you and the patient what to do if we do not have the enrollment information. Please note that the Member I.D. Card is used for identification purposes only and does not verify the Member's eligibility.

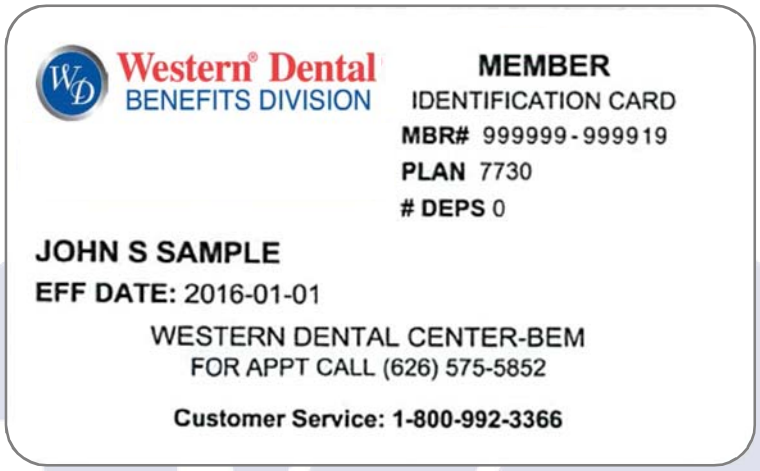
Your office will also receive an eligibility roster in the middle of the month. This roster will not show any capitation for members and it will not be accompanied by a check; however, this is an update of members' eligibility. All monies for members on the midmonth eligibility roster will be paid on the first of the following month.

HOW TO IDENTIFY A WESTERN DENTAL PLAN MEMBER

All Western Dental Plan enrollees should have an identification card in their possession. Below you will find a sample I.D. card for Western Dental Plan Members, along with an explanation of the information you will find on the card.

We suggest that you request a picture I.D. in addition to this card to help prevent fraudulent use of a member's benefits.

SAMPLE MEMBER IDENTIFICATION CARD



NOTE: If a member does not have an I.D. card or you have questions, please contact our Member Services Department at **1-800-992-3366** or our Provider Relations Department at **1-800-811-5111**.

COVERAGE ROSTER BY FACILITY

(Eligibility List)

The Western Dental ***"Coverage Roster by Facility"*** is the list you will receive on or before the tenth of each month. This list shows the names of all members who are eligible for dental care at your office.

The roster will show the following:

1) The name of the subscriber (employee)
2) The names of all covered dependents (spouse and children)
3) The benefit plan number for the subscriber (co-pay schedule to refer to)
4) The effective date of coverage
5) The group number, where applicable, and the member number
6) The member's last 4 digit social security number
7) The member's phone number
8) The member's preferred language

When calling to confirm eligibility of plan benefits, all information can be found on this roster.

FACILITY PAYMENT SUMMARY

This report was designed to help you understand how group and individual capitation payments are generated.

Using your ***"Facility Payment Summary"*** for reconciliation:

- **Group or Individual Coverage –** Matching the group or individual identification numbers on this form with the eligibility roster.
- **Capitation Amounts –** Adding the amounts paid and subtracting any adjustments.

If the plan or members "PAID THRU" date is not the current month or is not listed, a notation will read "* IF TREATED THIS MONTH, SUBMIT GUARANTEED CAPITATION FORM*" you should either:

Contact our Member Services Department at **1-800-992-3366** to verify eligibility before rendering services.

Complete a Guaranteed Capitation Form.

It is strongly recommended that you retain your payment summaries for reference and to reconcile against your roster. If you have any questions, please do not hesitate to call.

*****See roster samples on the pages following*****

WESTERN DENTAL SERVICES, INC.
530 S MAIN STREET
ORANGE, CA 92868

SAMPLE

Facility ID: *******
Facility Number: *****
Firm Number: *****

DENTAL OFFICE NAME
1234 DENTAL BOULEVARD
LOS ANGELES, CA 92111

ROSTER BY FACILITY - COVERAGE

Print Date: XX/XX/XXXX

Page No.: 1

DENTAL OFFICE NAME

Eligible As of : XX/XX/XXXX

Member\Dependent Name	DOB	Plan Code	Effective Date	Group ID	Member ID	SSN 4	Phone Number	Preferred Language
DOE, JOHN	03/18/1973	SDTEAM	04/01/2011	1234	12345	*-1234	(619) 213-8888	N/A
DOE, JOHN JR.	04/19/1994							
DOE, JANE	05/20/1995							
SAMPLE, PATRICIA	06/21/1946	SDPLUS	10/01/2014	246	67891	*-5678	(858) 279-1111	Spanish
NAME, HUGO, J	07/22/1967	SDPLUS	10/01/2014	246	23456	*-9123	(619) 220-2222	English

Members with 0 Dependents: 2
Members with 1 Dependent: 0
Members with 2 or More Dependents: 1
Total Number of Members: 3
Total Number of Dependents: 2
Total Dependents w/o Subscriber: 0

WESTERN DENTAL SERVICES, INC.
530 SOUTH MAIN STREET
ORANGE, CA 92868

EXPLANATION OF PAYMENTS

SAMPLE

Page: 1
Date: XX/XX/XXXX
Time: 4:22 pm

Check No.: XXXXX **Check Date:** XX/XX/XXXX

Firm: 12345 DENTAL OFFICE NAME

Facility: 56789 DENTAL OFFICE NAME
1234 DENTAL BOULEVARD
LOS ANGELES, CA 92111

Capitation

Group Name	Billing Cycle	Transaction Type	Capitation Type	Capitation Rate	Total Members	Total Dependents	Credit Note #	Amount
Facility: 56789 DENTAL OFFICE NAME 1234 DENTAL BOULEVARD LOS ANGELES, CA 92111								
GROUP COMPANY 1	05/01/2017	Active Current	Pmpm Cap		1	0	265897	$1.75
GROUP COMPANY 2	05/01/2017	Active Current	Pmpm Cap		2	0	266719	$5.00
GROUP COMPANY 3	05/01/2017	Active Current	Pmpm Cap		3	6	267853	$13.50
			DENTAL OFFICE NAME Total:		6	6		$20.25
			Total Firm 12345- DENTAL OFFICE NAM		6	6		$20.25

III.

COBRA

COBRA

The following section contains important information about the Consolidated Omnibus Budget Reconciliation Act of 1986.

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COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted on April 7, 1986. This law allows (under specific circumstances) members and their dependents of groups employing more than 20 employees (excluding churches and federal government health plans) to maintain the same health care benefits after their coverage would have normally ceased.

If any member/dependent becomes eligible under a COBRA qualifying event, the group should complete the Continuation of Benefits request form. This form must be submit it to Western Dental Services, Inc. no later than 60 days following the month that regular benefits are terminated.

QUALIFYING EVENTS AND DURATION OF COVERAGE

18 months coverage:

- Termination of employment
- Loss of coverage due to reduction of work hours

36 months of coverage:

- Divorce
- Death of a covered employee
- Legal Separation
- Employee spouse eligible for Medicare
- No longer eligible as dependent child

IV.

EMERGENCY CARE

EMERGENCY CARE

The following section contains important information about provider obligations to patients' emergency care access.

Emergency Care

Emergency Care means service required for alleviation of severe pain or bleeding and/or immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction or death. Dentist agrees to render all necessary dental services to each of the members of any group or individual during his regular office hours.

Dentist shall be available for after-hour emergency services as necessary.

Patient access to emergency dental treatment must be available on a 24-hour/seven day a week basis, as stated in your Dental Provider Contract, Article III, Section G.

Acute conditions should be treated as soon as possible. As required by State statutes, you should designate another dentist to treat emergencies that may arise when you are not available.

Your obligation to the patient is to relieve the immediate pain and any further treatment may be rescheduled for a later date.

As a courtesy, we would recommend each of the Plan Providers being available to see other Plan Provider members in emergency situations and charge only the appropriate copayment, should the need arise.

Emergency Care Reimbursement

If a dental emergency occurs while more than 50 miles from the member's Primary Care Provider, the MEMBER may have emergency services rendered by any licensed dentist in the area where such emergency occurs. The plan will provide a maximum allowable benefit of **$50.00** to **100.00** (depending on the member's plan) for the following:

1. **Control of bleeding**
2. **Control of infection**
3. **Relief of pain associated with dental problems**

WDS requires an itemized statement of services from the non-primary care provider or out-of-network provider for verification of benefit reimbursement.

V.

PLAN BENEFITS

PLAN BENEFITS

The following sections contain important information regarding plan benefits, limitations & exclusions and the most recent CDT code changes.

The member pays you according to the schedule of co-payments on their corresponding plan.

The Principal Limitations and Exclusions that are applicable are included at the end of each plan.

STANDARD GROUP PLANS

This section contains the standard group plans created by Western Dental for all groups. Member co-payments are listed with plan limitations and exclusions.

Western Dental Services CDT 2021 Group Plans
Member Copayments

ADA CODE	* ADA DESCRIPTION	7700	7710	7720	7730	7740	7750	7760	7780	7781	Metal Charge	Min Guarantee Including Metal Charge
CAPITATION (Per Member)		$ 3.00	$ 2.50	$ 2.25	$ 2.00	$ 1.75	$ 1.50	$ 1.25	$ 1.00	$ 1.00		
CLINICAL ORAL EVALUATIONS												
D0120	Periodic oral examination - established patient	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0140	Limited oral evaluation - problem focused	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0145	Oral evaluation for patient under three years of age and counseling with primary caregive	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0150	Comprehensive oral evaluation - new or established patient	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0171	Re-evaluation - post operative office visit	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0180	Comprehensive periodontal evaluation - new or established patient	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0190	Screening of a patient	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0191	Assessment of a patient	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)												
D0210	Intraoral - complete series of radiographic images	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$10
D0220	Intraoral - periapical radiographic image	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0230	Intraoral - periapical each additional film	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0240	Intraoral - occlusal radiographic	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0250	Extra-oral single film	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0270	Bitewing - single film	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0272	Bitewings - two films	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0273	Bitewings - three films	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0274	Bitewings - four films	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0277	Vertical bitewings - 7 to 8 films	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0330	Panoramic film	$0	$0	$0	$0	$0	$0	$0	$25	$25	N/A	$10
D0340	Cephalometric Film	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0350	Oral/Facial Images	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
TESTS AND EXAMINATIONS												
D0419	Assement of salivary flow by measurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0460	Pulp vitality tests	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0470	Diagnostic casts	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0601	Caries risk assessment and documentation, with a finding of low risk	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0603	Caries risk assessment and documentation, with a finding of high risk	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0701	Panoramic radiographic image- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0702	2-D cephalometric radiographic- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0703	2-D oral/facial photographic image obtianed intra-orally or extra orally - image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0705	extra-oral posterior dental radiographic image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0706	intraoral- occlusal radiographic image- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0707	intraoral- periapical radiographic image- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0708	intraoral- bitewing radiographic image- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0709	intraoral- complete series of radiographic images- image capture only	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
Oral Pathology Laboratory												
D0472	Accession of tissue, gross examination, preparation and transmission of written repor	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written repor	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written repor	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
DENTAL PROPHYLAXIS												
D1110	Prophylaxis - adult	$0	$0	$0	$0	$0	$0	$0	$10	$0	N/A	$20
	D1110 and D1120 additional prophy exceeding two in a 12 month period	$45	$45	$45	$45	$45	$45	$45	$45	$45	N/A	$20
D1120	Prophylaxis - child	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$15
	D1110 and D1120 additional prophy exceeding two in a 12 mont	$45	$45	$45	$45	$45	$45	$45	$45	$45	N/A	$15
TOPICAL FLUORIDE TREATMENT (office procedure)												
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0	$0	$0	$0	$0	$0	$0	$10	$10	N/A	N/A
D1208	Topical application of fluoride- excluding varnish - child to age 1 *limited to 2 per 12 month period*	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
OTHER PREVENTIVE SERVICES												
D1310	Nutritional Counseling for control of dental disease	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1320	Tobacco counseling for the control and prevention of oral diseas	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1330	Oral hygiene instructions	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1351	Sealant - per tooth	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$10
D1352	Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1353	Sealant repair - per tooth - limited to permanent molars through age 15	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1354	Interim caries arresting medicament application - per tooth	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1355	caries preventive medicament application - per tooth	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
SPACE MAINTENANCE (passive appliances)												
D1510	Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	N/A
D1516	Space maintainer - fixed - bilateral - maxillary	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	N/A
D1517	Space maintainer - fixed - bilateral - mandibular	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	N/A
D1520	Space maintainer - removable - unilateral	$0	$15	$30	$40	$50	$75	$135	$135	$135	N/A	N/A
D1526	Space maintainer - removable - maxillary	$0	$20	$35	$45	$60	$90	$160	$160	$160	N/A	N/A
D1527	Space maintainer - removable - mandibular	$0	$20	$35	$45	$60	$90	$160	$160	$160	N/A	N/A
D1551	Re-cement or re-bond bilateral space maintainer	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1552	Re-cement or re-bond unilateral space maintainer	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D1556	Removal of fixed unilateral space maintainer - per quadrant	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D1557	Removal of fixed bilateral space maintainer maxillary	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D1558	Removal of fixed bilateral space maintainer mandibular	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D1575	Distal shoe space maintainer - fixed unilateral	$0	$15	$30	$40	$50	$75	$135	$135	$135	N/A	N/A
AMALGAM RESTORATIONS (including polishing)												
D2140	Amalgam - one surface, primary or permanent	$0	$0	$0	$0	$5	$10	$20	$30	$30	N/A	$5
D2150	Amalgam - two surfaces, primary or permanent	$0	$0	$0	$0	$10	$15	$30	$40	$40	N/A	$10
D2160	Amalgam - three surfaces, primary or permanent	$0	$0	$0	$0	$10	$15	$30	$40	$40	N/A	$10
D2161	Amalgam - four or more surfaces, primary or permanent	$0	$0	$0	$0	$15	$25	$45	$55	$55	N/A	$15
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT												
D2330	Resin-based composite - one surface, anterior	$0	$0	$0	$0	$5	$10	$20	$30	$30	N/A	$10
D2331	Resin-based composite - two surfaces, anterior	$0	$0	$0	$0	$10	$15	$30	$40	$40	N/A	$15
D2332	Resin-based composite - three surfaces, anterior	$0	$0	$0	$0	$10	$15	$30	$40	$40	N/A	$15
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior	$0	$0	$0	$0	$15	$25	$45	$55	$55	N/A	$20
D2390	Resin-based composite crown, anterior	$0	$0	$0	$0	$25	$40	$70	$80	$80	N/A	$20

Western Dental Services CDT 2021 Group Plans
Member Copayments

ADA CODE		* ADA DESCRIPTION	7700	7710	7720	7730	7740	7750	7760	7780	7781	Metal Charge	Min Guarantee Including Metal Charge
CAPITATION (Per Member)			$ 3.00	$ 2.50	$ 2.25	$ 2.00	$ 1.75	$ 1.50	$ 1.25	$ 1.00	$ 1.00		
D2391		Resin-based composite - one surface, posterior	$55	$55	$55	$55	$55	$55	$55	$65	$65	N/A	$55
D2392		Resin-based composite - two surfaces, posterior	$65	$65	$65	$65	$65	$65	$65	$75	$75	N/A	$65
D2393		Resin-based composite - three surfaces, posterior	$75	$75	$75	$75	$75	$75	$75	$85	$85	N/A	$75
D2394		Resin-based composite - four or more surfaces, posterior	$85	$85	$85	$85	$85	$85	$85	$95	$95	N/A	$85
INLAY/ONLAY RESTORATIONS													
D2510	◆	Inlay - metallic - one surface	$0	$0	$50	$65	$85	$130	$165	$165	$165	$125	$190
D2520	◆	Inlay - metallic - two surfaces	$0	$0	$60	$75	$95	$145	$255	$255	$255	$125	$200
D2530	◆	Inlay - metallic - three or more surfaces	$0	$0	$60	$75	$95	$145	$255	$255	$255	$125	$200
D2542	◆	Onlay - metallic - two surfaces	$0	$0	$65	$85	$110	$165	$290	$290	$290	$125	$210
D2543	◆	Onlays - metallic - three surfaces	$0	$0	$65	$85	$110	$165	$290	$290	$290	$125	$210
D2544	◆	Onlays - metallic - four or more surfaces	$0	$0	$70	$90	$115	$175	$310	$310	$310	$125	$210
D2610		Inlay - porcelain/ceramic - 1 surface	$185	$245	$330	$410	$510	$510	$510	$510	$510	N/A	N/A
D2620		Inlay - porcelain/ceramic - 2 surfaces	$195	$260	$345	$430	$535	$535	$535	$535	$535	N/A	N/A
D2630		Inlay - porcelain/ceramic - 3 or more surfaces	$205	$275	$365	$460	$570	$570	$570	$570	$570	N/A	N/A
D2642		Onlay, porcelain/ceramic - 2 surfaces	$200	$270	$355	$445	$555	$555	$555	$555	$555	N/A	N/A
D2643		Onlay, porcelain/ceramic - 3 surfaces	$215	$290	$385	$480	$600	$600	$600	$600	$600	N/A	N/A
D2651		Inlay - resin-based composite - 2 surfaces	$145	$190	$255	$320	$400	$400	$400	$400	$400	N/A	N/A
D2652		Inlay - resin-based composite - 3 or more surfaces	$150	$200	$270	$335	$420	$420	$420	$420	$420	N/A	N/A
D2662		Onlay - resin-based composite - 2 surfaces	$135	$175	$235	$295	$365	$365	$365	$365	$365	N/A	N/A
D2663		Onlay - resin-based composite - 3 surfaces	$155	$205	$275	$340	$425	$425	$425	$425	$425	N/A	N/A
CROWNS - SINGLE RESTORATIONS ONLY													
D2710		Crown - resin-based composite (indirect)	$0	$25	$45	$60	$75	$115	$205	$205	$205	N/A	$120
D2712		Crown - 3/4 resin-based composite (indirect)	$0	$25	$45	$60	$75	$115	$205	$205	$205	N/A	$120
D2720	◆	Crown - resin with high noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
D2721		Crown - resin with predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	N/A	$210
D2722	◆	Crown - resin with noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$300
D2740		Crown - porcelain/ceramic	$0	$55	$105	$135	$170	$255	$450	$475	$475	N/A	$350
D2750	◆	Crown - porcelain fused to high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2751		Crown - porcelain fused to predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$210
D2752	◆	Crown - porcelain fused to noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2753	◆	Crown- porcelain fused to titanium or titanium alloy	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2780	◆	Crown - 3/4 cast high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2781		Crown - 3/4 cast predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$210
D2782	◆	Crown - 3/4 cast noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2783		Crown - 3/4 porcelain/ceramic	$0	$50	$100	$130	$165	$250	$440	$465	$465	N/A	$200
D2790	◆	Crown - full cast high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
D2791		Crown - full cast predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$115
D2792	◆	Crown - full cast noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$240
D2794	◆	Crown - titanium	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$240
D2799		Provisional crown - To be used at least 6 months during healing	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$10
OTHER RESTORATIVE SERVICES													
D2910		Recement inlay, onlay, or partial coverage restoration	$0	$0	$5	$5	$10	$15	$30	$30	$30	N/A	N/A
D2915		Recement cast or prefabricated post and core	$0	$0	$5	$5	$10	$15	$30	$30	$30	N/A	N/A
D2920		Recement crown	$0	$0	$5	$5	$10	$15	$30	$30	$30	N/A	N/A
D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0	$15	$20	$30	$40	$50	$60	$70	$80	N/A	N/A
D2930		Prefabricated stainless steel crown - primary tooth	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	$10
D2931		Prefabricated stainless steel crown - permanent tooth	$0	$15	$25	$30	$40	$60	$105	$105	$105	N/A	$10
D2932		Prefabricated resin crown	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$10
D2933		Prefabricated stainless steel crown with resin window	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$10
D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$10
D2940		Sedative filling	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D2950		Core buildup, involving and including any pins	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D2951		Pin retention - per tooth, in addition to restoration	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D2952		Post and core in addition to crown, indirectly fabricated	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	$50
D2953		Each additional indirectly fabricated post - same tooth	$0	$10	$10	$10	$10	$10	$10	$10	$10	N/A	$0
D2954		Prefabricated post and core in addition to crown	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	$50
D2955		Post removal (not in conjunction with endodontic therapy)	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D2957		Each additional prefabricated post - same tooth	$0	$10	$10	$10	$10	$10	$10	$10	$10	N/A	$0
D2962		Labial veneer - porcelain laminate (laboratory)	$600	$600	$600	$600	$600	$600	$590	$590	$590	N/A	N/A
		Rebond Veneer	$80	$80	$80	$80	$80	$80	$80	$80	$80	N/A	N/A
D2971		Additional procedures to construct new crown under existing partial denture framework	$0	$15	$25	$30	$40	$60	$95	$95	$95	N/A	$30
D2980		Crown repair, by report	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	@	Lumineer	$600	$600	$600	$600	$600	$600	$600	$600	$600	N/A	N/A
PULP CAPPING													
D3110		Pulp cap - direct (excluding final restoration)	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D3120		Pulp cap - indirect (excluding final restoration)	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
PULPOTOMY													
D3220		Therapeutic pulpotomy (excluding final restoration)	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D3221		Pulpal debridement, primary and permanent teeth	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
ENDODONTIC THERAPY ON PRIMARY TEETH													
D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration	$0	$10	$15	$15	$20	$30	$55	$55	$55	N/A	N/A
D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)													
D3310		Anterior (excluding final restoration)	$0	$20	$40	$50	$65	$100	$175	$200	$200	N/A	$40
D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$0	$30	$60	$80	$100	$150	$265	$300	$300	N/A	$80
D3330		Endodontic therapy, molar tooth (excluding final restoration)	$0	$40	$75	$100	$125	$190	$335	$550	$550	N/A	$250
ENDODONTIC RETREATMENT													
D3346		Retreatment of previous root canal therapy - anterior	$0	$25	$45	$60	$75	$115	$205	$450	$450	N/A	$40
D3347		Retreatment of previous root canal therapy - premolar	$0	$30	$60	$80	$100	$150	$265	$500	$500	N/A	$80
D3348		Retreatment of previous root canal therapy - molar	$0	$50	$95	$125	$160	$240	$420	$675	$675	N/A	$250
Apexification/ Recalcifica													
APICOECTOMY/PERIRADICULAR SERVICES												N/A	
D3410		Apicoectomy- anterior	$0	$25	$45	$60	$75	$115	$205	$475	$475	N/A	N/A
D3421		Apicoectomy premolar (first root)	$0	$25	$45	$60	$75	$115	$205	$475	$475	N/A	N/A
D3425		Apicoectomy/periradicular surgery - molar (first root)	$0	$25	$45	$60	$75	$115	$205	$505	$505	N/A	N/A
D3426		Apicoectomy (each additional root)	$0	$10	$20	$25	$35	$55	$100	$140	$140	N/A	N/A
D3430		Retrograde filling - per root	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D3450		Root amputation - per root	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D3471		Surgical repair of root resorption-anterior	$0	$25	$45	$60	$75	$115	$205	$475	$475	N/A	N/A
D3472		Surgical repair of root resorption-premolar	$0	$25	$45	$60	$75	$115	$205	$475	$475	N/A	N/A
D3473		Surgical repair of root resorption-molar	$0	$25	$45	$60	$75	$115	$205	$505	$505	N/A	N/A
D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0	$35	$55	$70	$85	$125	$215	$515	$515	N/A	N/A
D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0	$45	$65	$85	$100	$150	$225	$525	$525	N/A	N/A
D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0	$60	$80	$100	$120	$160	$235	$535	$535	N/A	N/A
OTHER ENDODONTIC PROCEDURES													
D3910		Surgical procedure for isolation of tooth with rubber dam	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
D3920		Hemisection (including any root removal), not including roo canal therapy	$0	$15	$25	$30	$40	$60	$105	$105	$105	N/A	N/A
D3950		Canal preparation and fitting of preformed dowel or post	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
SURGICAL SERVICES (including usual postoperative care)													
D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadran	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	N/A

Western Dental Services CDT 2021 Group Plans
Member Copayments

ADA CODE	* ADA DESCRIPTION	7700	7710	7720	7730	7740	7750	7760	7780	7781	Metal Charge	Min Guarantee Including Metal Charge
CAPITATION (Per Member)		$ 3.00	$ 2.50	$ 2.25	$ 2.00	$ 1.75	$ 1.50	$ 1.25	$ 1.00	$ 1.00		
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth o bounded teeth spaces per quadran	$0	$10	$15	$15	$20	$30	$55	$55	$55	N/A	N/A
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadran	$0	$15	$30	$40	$50	$75	$135	$135	$135	N/A	N/A
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadran	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	N/A
D4245	Apically positioned flap	$0	$20	$40	$50	$65	$100	$175	$275	$275	N/A	N/A
D4249	Clinical crown lengthening - hard tissue	$0	$25	$45	$60	$75	$115	$205	$475	$475	N/A	N/A
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$0	$60	$115	$150	$190	$285	$500	$600	$600	N/A	N/A
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$0	$10	$20	$25	$35	$55	$100	$450	$450	N/A	N/A
D4263	Bone replacement graft - first site in quadrant	$0	$50	$95	$125	$160	$240	$325	$475	$475	N/A	N/A
D4264	Bone replacement graft - each additional site in quadrant	$0	$40	$75	$100	$125	$175	$175	$275	$275	N/A	N/A
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0	$15	$30	$40	$50	$75	$135	$275	$275	N/A	N/A
NON-SURGICAL PERIODONTAL SERVICES												
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$0	$10	$15	$20	$25	$40	$70	$100	$100	N/A	$15
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$0	$5	$5	$5	$10	$15	$30	$75	$75	N/A	$5
D4346	Scaling in presence of generalized moderate or severe gingiva inflammation - full mouth, after oral evaluatio	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	$20
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visi	$0	$10	$15	$20	$25	$40	$70	$100	$70	N/A	$20
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	$0	$20	$35	$45	$60	$90	$95	$95	$95	N/A	N/A
OTHER PERIODONTAL SERVICES												
D4910	Periodontal maintenance	$0	$15	$25	$40	$50	$75	$90	$90	$90	N/A	N/A
D4921	Gingival Irrigation - Per Quadrant	$0	$10	$20	$25	$35	$55	$75	$75	$75	N/A	N/A
COMPLETE DENTURES (including routine post-delivery care)												
D5110	Complete denture - maxillary	$0	$60	$120	$160	$200	$300	$525	$525	$525	N/A	$330
D5120	Complete denture - mandibular	$0	$60	$120	$160	$200	$300	$525	$525	$525	N/A	$330
D5130	Immediate denture - maxillary	$0	$70	$135	$175	$220	$330	$580	$580	$580	N/A	$355
D5140	Immediate denture - mandibular	$0	$70	$135	$175	$220	$330	$580	$580	$580	N/A	$355
PARTIAL DENTURES (including routine post-delivery care)												
D5211	Maxillary partial denture - resin base (including any conventiona clasps, rests and teeth)	$0	$40	$75	$95	$120	$180	$315	$315	$315	N/A	$250
D5212	Mandibular partial denture - resin base (including an conventional clasps, rests and teeth	$0	$40	$75	$95	$120	$180	$315	$315	$315	N/A	$250
D5213	Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5221	Immediate maxillary partial denture - resin base (including an conventional clasps, rests and teeth	$0	$40	$75	$95	$120	$180	$315	$315	$315	N/A	$250
D5222	Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth	$0	$40	$75	$95	$120	$180	$315	$315	$315	N/A	$250
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5225	Maxillary partial denture - flexible base (including any clasps rests and teeth)	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5226	Mandibular partial denture - flexible base (including any clasps rests and teeth)	$0	$60	$115	$150	$190	$285	$500	$500	$500	N/A	$360
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillar	$0	$45	$85	$110	$140	$210	$370	$370	$370	N/A	N/A
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibula	$0	$45	$85	$110	$140	$210	$370	$370	$370	N/A	N/A
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadran	$0	$45	$85	$110	$140	$210	$370	$370	$370	N/A	N/A
D5286	Removable unilateral partial denture - one piece resin (includin clasps and teeth) per quadran	$0	$45	$85	$110	$140	$210	$370	$370	$370	N/A	N/A
ADJUSTMENTS TO DENTURES												
D5410	Adjust complete denture - maxillary	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D5411	Adjust complete denture - mandibular	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D5421	Adjust partial denture - maxillary	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
D5422	Adjust partial denture - mandibular	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
REPAIRS TO COMPLETE DENTURES												
D5511	Repair broken complete denture base, mandibular	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5512	Repair broker complete denture base, maxillary	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
REPAIRS TO PARTIAL DENTURES												
D5611	Repair resin partial denture base, mandibular	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5612	Repair resin partial denture base, maxillary	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5621	Repair cast partial framework, mandibular	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5622	Repair cast partial framework, maxillary	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5630	Repair or replace broken clasp- per tooth	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5640	Replace broken teeth - per tooth	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5650	Add tooth to existing partial denture	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5660	Add clasp to existing partial denture - per tooth	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$0	$40	$75	$100	$125	$190	$335	$335	$335	N/A	N/A
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$0	$40	$75	$100	$125	$190	$335	$335	$335	N/A	N/A
DENTURE REBASE PROCEDURES												
D5710	Rebase complete maxillary denture	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$80
D5711	Rebase complete mandibular denture	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$80
D5720	Rebase maxillary partial denture	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$70
D5721	Rebase mandibular partial denture	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$70
DENTURE RELINE PROCEDURES												
D5730	Reline complete maxillary denture (chairside)	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5731	Reline complete mandibular denture (chairside)	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5740	Reline maxillary partial denture (chairside)	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5741	Reline mandibular partial denture (chairside)	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
D5750	Reline complete maxillary denture (laboratory)	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$80
D5751	Reline complete mandibular denture (laboratory)	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$80
D5760	Reline maxillary partial denture (laboratory)	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$70
D5761	Reline mandibular partial denture (laboratory)	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	$70
OTHER REMOVABLE PROSTHETIC SERVICES												
D5810	Interim complete denture (maxillary)	$0	$75	$150	$195	$245	$370	$480	$480	$480	N/A	N/A
D5811	Interim complete denture (mandibular)	$0	$75	$150	$195	$245	$370	$480	$480	$480	N/A	N/A
D5820	Interim partial denture (maxillary)	$0	$30	$60	$75	$95	$145	$255	$255	$255	N/A	N/A
D5821	Interim partial denture (mandibular)	$0	$30	$60	$75	$95	$145	$255	$255	$255	N/A	N/A
D5850	Tissue conditioning, maxillary	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	N/A
D5851	Tissue conditioning, mandibular	$0	$10	$20	$25	$35	$55	$100	$100	$100	N/A	N/A

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ADA CODE			* ADA DESCRIPTION	7700	7710	7720	7730	7740	7750	7760	7780	7781	Metal Charge	Min Guarantee Including Metal Charge
CAPITATION (Per Member)				$ 3.00	$ 2.50	$ 2.25	$ 2.00	$ 1.75	$ 1.50	$ 1.25	$ 1.00	$ 1.00		
IMPLANT SERVICES														
	D6010	@	Surgical placement of implant body: endosteal implant	$1,690	$1,690	$1,690	$1,690	$1,690	$1,690	$1,690	$1,690	$1,690	N/A	N/A
	D6058	@	Abutment supported porcelain/ceramic crown	$960	$960	$960	$960	$960	$960	$960	$960	$960	N/A	N/A
	D6059	@	Abutment supported porcelain fused to metal crown (high noble metal)	$965	$965	$965	$965	$965	$965	$965	$965	$965	N/A	N/A
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915	$915	$915	$915	$915	$915	$915	$915	$915	N/A	N/A
	D6061	@	Abutment supported porcelain fused to metal crown (noble metal)	$930	$930	$930	$930	$930	$930	$930	$930	$930	N/A	N/A
	D6062	@	Abutment supported cast metal crown (high noble metal)	$925	$925	$925	$925	$925	$925	$925	$925	$925	N/A	N/A
	D6063	@	Abutment supported cast metal crown (predominantly base metal)	$800	$800	$800	$800	$800	$800	$800	$800	$800	N/A	N/A
	D6064	@	Abutment supported cast metal crown (noble metal)	$840	$840	$840	$840	$840	$840	$840	$840	$840	N/A	N/A
	D6065	@	Implant supported porcelain/ceramic crown	$955	$955	$955	$955	$955	$955	$955	$955	$955	N/A	N/A
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal	$935	$935	$935	$935	$935	$935	$935	$935	$935	N/A	N/A
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910	$910	$910	$910	$910	$910	$910	$910	$910	N/A	N/A
	D6068	@	Abutment supported retainer for porcelain/ceramic FPD	$975	$975	$975	$975	$975	$975	$975	$975	$975	N/A	N/A
	D6069	@	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965	$965	$965	$965	$965	$965	$965	$965	$965	N/A	N/A
	D6070	@	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915	$915	$915	$915	$915	$915	$915	$915	$915	N/A	N/A
	D6071	@	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930	$930	$930	$930	$930	$930	$930	$930	$930	N/A	N/A
	D6072	@	Abutment supported retainer for cast metal FPD (high noble metal)	$950	$950	$950	$950	$950	$950	$950	$950	$950	N/A	N/A
	D6073	@	Abutment supported retainer for cast metal FPD (predominantly base metal)	$860	$860	$860	$860	$860	$860	$860	$860	$860	N/A	N/A
	D6074	@	Abutment supported retainer for cast metal FPD (noble metal)	$925	$925	$925	$925	$925	$925	$925	$925	$925	N/A	N/A
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closur	$0	$5	$5	$5	$10	$15	$30	$30	$30	N/A	$5
	D6094	@	Abutment supported crown - (titanium)	$600	$600	$600	$600	$600	$600	$600	$600	$600	N/A	N/A
	D6191		Semi-precision abutment - placement	$600	$600	$600	$600	$600	$600	$600	$600	$600	N/A	N/A
	D6192		Semi-precision attachment - placement	$600	$60	$600	$600	$600	$600	$600	$600	$600	N/A	N/A
	D6194	@	Abutment supported retainer crown for FPD (titanium)	$500	$500	$500	$500	$500	$500	$500	$500	$500	N/A	N/A
	D6195	@	Abutment supported retainer - porcelain fused to titanium or titanium alloy	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
FIXED PARTIAL DENTURE PONTICS														
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$0	$50	$100	$130	$165	$250	$400	$400	$400	N/A	$195
	D6210	◆	Pontic - cast high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
	D6211		Pontic - cast predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$175
	D6212	◆	Pontic - cast noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
	D6214	◆	Pontic - titanium	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$175
	D6240	◆	Pontic - porcelain fused to high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
	D6241		Pontic - porcelain fused to predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$170
	D6242	◆	Pontic - porcelain fused to noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
	D6243	◆	Pontic - porcelain fused to titanium or titanium alloys	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$335
	D6245		Pontic - porcelain/ceramic	$0	$50	$100	$130	$165	$250	$440	$465	$465	N/A	$195
	D6250	◆	Pontic - resin with high noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
	D6251		Pontic - resin with predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	N/A	$295
	D6252	◆	Pontic - resin with noble metal	$0	$45	$90	$115	$145	$220	$385	$410	$410	$125	$295
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS														
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$0	$35	$70	$90	$115	$175	$250	$250	$250	N/A	N/A
FIXED PARTIAL DENTURE RETAINERS - CROWNS														
	D6710		Crown - indirect resin based composite	$0	$50	$100	$130	$165	$250	$440	$440	$440	N/A	$195
	D6720	◆	Crown - resin with high noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6721		Crown - resin with predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	N/A	$210
	D6722	◆	Crown - resin with noble metal	$0	$50	$100	$130	$165	$250	$440	$440	$440	$125	$335
	D6740		Crown - porcelain/ceramic	$0	$50	$100	$130	$165	$250	$440	$440	$440	N/A	$205
	D6750	◆	Crown - porcelain fused to high noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6751		Crown - porcelain fused to predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	N/A	$205
	D6752	◆	Crown - porcelain fused to noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6753	◆	Retainer crown - porcelain fused to titanium or titanium alloys	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6780	◆	Crown - 3/4 cast high noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6781		Crown - 3/4 cast predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	N/A	$205
	D6782	◆	Crown - 3/4 cast noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6783		Crown - 3/4 cast porcelain/ceramic	$0	$50	$100	$130	$165	$250	$440	$440	$440	N/A	$205
	D6784	◆	Retainer crown 3/4 - titaninium and titanium alloys	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6790	◆	Crown - full cast high noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6791		Crown - full cast predominantly base metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	N/A	$205
	D6792	◆	Crown - full cast noble metal	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$335
	D6794	◆	Crown - titanium	$0	$45	$90	$115	$145	$220	$385	$385	$385	$125	$240
OTHER FIXED PARTIAL DENTURE SERVICES														
	D6930		Recement fixed partial denture	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D6940		Stress breaker	$0	$45	$85	$110	$140	$180	$180	$180	$180	N/A	N/A
	D6980		Fixed partial denture repair, by report	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)														
	D7111		Extraction, coronal remnants - primary tooth	$0	$5	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0	$10	$20	$25	$35	$55	$95	$95	$95	N/A	N/A
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)														
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0	$5	$15	$20	$25	$40	$70	$125	$125	N/A	$20
	D7220		Removal of impacted tooth - soft tissue	$0	$20	$40	$50	$65	$100	$175	$175	$175	N/A	$35
	D7230		Removal of impacted tooth - partially bony	$0	$25	$45	$60	$75	$115	$205	$250	$250	N/A	$40
	D7240		Removal of impacted tooth - completely bony	$0	$35	$70	$90	$115	$175	$310	$310	$310	N/A	$45
	D7241		Removal of impacted tooth - completely bony, with unusua surgical complications	$0	$35	$70	$90	$115	$175	$310	$310	$310	N/A	N/A
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0	$35	$70	$90	$115	$175	$175	$250	$250	N/A	$45
OTHER SURGICAL PROCEDURES														
	D7270		Tooth reimplantation and/or stabilization of accidentally evulsed	$0	$95	$190	$250	$315	$340	$340	$340	$340	N/A	N/A
	D7280		Surgical access of an unerupted tooth	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
	D7283		Placement of device to facilitate eruption of impacted tooth	$0	$5	$5	$5	$10	$15	$30	$30	$30	N/A	N/A
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0	$20	$40	$50	$65	$100	$175	$175	$175	N/A	N/A
	D7286		Biopsy of oral tissue - soft (all others)	$0	$20	$40	$50	$65	$100	$175	$175	$175	N/A	N/A
	D7288		Brush biopsy - transepithelial sample collection	$0	$20	$40	$50	$65	$65	$65	$65	$65	N/A	N/A
ALVEOLOPLASTY (surgical preparation of ridge for dentures)														
	D7310		Alveoloplasty in conjunction with extractions - four or more teet or tooth spaces, per quadrant	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
	D7311		Alveoloplasty in conjunction with extractions - one to three teet or tooth spaces, per quadrant	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
	D7320		Alveoloplasty not in conjunction with extractions - four or mor teeth or tooth spaces, per quadrant	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
	D7321		Alveoloplasty not in conjunction with extractions - one to thre teeth or tooth spaces, per quadrant	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS													N/A	N/A

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ADA CODE			* ADA DESCRIPTION	7700	7710	7720	7730	7740	7750	7760	7780	7781	Metal Charge	Min Guarantee Including Metal Charge
CAPITATION (Per Member)				$ 3.00	$ 2.50	$ 2.25	$ 2.00	$ 1.75	$ 1.50	$ 1.25	$ 1.00	$ 1.00		
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0	$20	$40	$50	$65	$100	$175	$175	$175	N/A	N/A
Excision of Bone Tissue														
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0	$115	$225	$300	$375	$565	$620	$620	$620	N/A	N/A
	D7485		Surgical reduction of osseous tuberosity	$0	$115	$225	$300	$375	$565	$615	$615	$615	N/A	N/A
SURGICAL INCISION														
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
	D7520		Incision and drainage of abscess - extraoral soft tissue	$0	$15	$25	$30	$40	$60	$105	$105	$105	N/A	N/A
OTHER REPAIR PROCEDURES														
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D7961		buccal/labial frenectomy	$0	$10	$20	$25	$35	$55	$100	$185	$185	N/A	N/A
	D7962		lingual frenectomy	$0	$10	$20	$25	$35	$55	$100	$185	$185	N/A	N/A
	D7963		Frenuloplasty	$0	$10	$15	$15	$20	$30	$55	$185	$185	N/A	N/A
	D7970		Excision of hyperplastic tissue - per arch	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	N/A
	D7971		Excision of pericoronal gingiva	$0	$10	$15	$20	$25	$40	$70	$70	$70	N/A	N/A
COMPREHENSIVE ORTHODONTIC TREATMENT														
	D8010		Limited orthodontic treatment of the primary dentition	$800	$800	$800	$800	$800	$800	$800	$1,500	$1,500	N/A	N/A
	D8020		Limited orthodontic treatment of the transitional dentition	$800	$800	$800	$800	$800	$800	$800	$1,500	$1,500	N/A	N/A
	D8030		Limited orthodontic treatment of the adolescent dentition	$800	$800	$800	$800	$800	$800	$800	$1,500	$1,500	N/A	N/A
	D8040		Limited orthodontic treatment of the adult dentition	$800	$800	$800	$800	$800	$800	$800	$1,500	$1,500	N/A	N/A
	D8050		Interceptive orthodontic treatment of the primary dentition	$950	$950	$950	$950	$950	$950	$950	$1,750	$1,750	N/A	N/A
	D8060		Interceptive orthodontic treatment of the transitional dentition	$950	$950	$950	$950	$950	$950	$950	$1,750	$1,750	N/A	N/A
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$2,400	$2,400	N/A	N/A
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$1,600	$2,400	$2,400	N/A	N/A
	D8090		Comprehensive orthodontic treatment of the adult dentition	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,100	$2,700	$2,700	N/A	N/A
OTHER ORTHODONTIC SERVICES														
	D8660		Pre-orthodontic treatment visit	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250	$250	$250	$250	$250	$250	$250	$250	$250	N/A	N/A
	D8999		Orthodontic records fee	$275	$275	$275	$275	$275	$275	$275	$275	$275	N/A	N/A
UNCLASSIFIED TREATMENT														
	D9110		Palliative (emergency) treatment of dental pain - minor procedure	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
ANESTHESIA														
	D9210		Local anesthesia not in conjunction with operative or surgica procedures	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9211		Regional block anesthesia	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9212		Trigeminal division block anesthesia	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9215		Local anesthesia	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9222		Deep sedation/general anesthesia - first 15 minutes	$0	$75	$150	$150	$150	$150	$150	$150	$150	N/A	N/A
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$0	$75	$150	$150	$150	$150	$150	$150	$150	N/A	N/A
	D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$0	$15	$30	$35	$45	$45	$45	$45	$45	N/A	N/A
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$0	$70	$135	$150	$150	$150	$150	$150	$150	N/A	N/A
	D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$0	$70	$135	$150	$150	$150	$150	$150	$150	N/A	N/A
PROFESSIONAL CONSULTATION														
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
PROFESSIONAL VISITS														
	D9430		Office visit for observation (during regularly scheduled hours) no other services performed	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9440		Office visit, after regularly scheduled hours	$0	$15	$30	$40	$50	$75	$95	$95	$95	N/A	N/A
MISCELLANEOUS SERVICES														
	D9910		Application of desensitizing medicament	$0	$10	$20	$25	$35	$35	$35	$35	$35	N/A	N/A
	D9932		Cleaning and inspection of removable complete denture, maxilla	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9933		Cleaning and inspection of removable complete denture, mandib	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9934		Cleaning and inspection of removable partial denture maxillary	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9935		Cleaning and inspection of removable partial denture, mandibula	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9944		Occlusal guard - hard appliance, full arch	$0	$75	$150	$200	$250	$250	$250	$250	$250	N/A	N/A
	D9945		Occlusal guard - soft appliance, full arch	$0	$75	$150	$200	$250	$250	$250	$250	$250	N/A	N/A
	D9946		Occlusal guard - hard appliance, partial arch	$0	$75	$150	$200	$250	$250	$250	$250	$250	N/A	N/A
	D9951		Occlusal adjustment - limited	$0	$5	$10	$10	$15	$25	$45	$45	$45	N/A	N/A
	D9952		Occlusal adjustment - complete	$0	$15	$30	$35	$45	$70	$125	$125	$125	N/A	N/A
	D9972		External bleaching - per arch - take home trays	$100	$100	$100	$100	$100	$100	$100	$100	$100	N/A	N/A
	D9975		External bleaching for home application, per arch; includes materials and fabrication of custom trays	$100	$100	$100	$100	$100	$100	$100	$100	$100	N/A	N/A
	NON CLINICAL PROCEDURES													
	D9986		Missed appointment	$0	$0	$0	$0	$0	$0	$0	$15	$15	N/A	N/A
	D9987		Cancelled appointment	$0	$0	$0	$0	$0	$0	$0	$15	$15	N/A	N/A
	D9990		Certified Translation or Sign Language Services - per visit	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A
	D9997		Dental case management - patients with special health care needs	$0	$0	$0	$0	$0	$0	$0	$0	$0	N/A	N/A

FOOTNOTES

◆ **Metal charges apply to a maximum of $125**

@ **Where available**

Western Dental Services CDT 2024 Group Plans
Member Copayments

	ADA CODE		* ADA DESCRIPTION	8000	8001	8002	8003	Minimum Guarantee Schedule
CAPITATION (Per Member)				**$ 2.50**	**$ 2.50**	**$ 2.50**	**$ 2.50**	
CLINICAL ORAL EVALUATIONS								
	D0120		Periodic oral examination - established patient	$0	$0	$0	$0	$15.00
	D0140		Limited oral evaluation - problem focused	$0	$0	$0	$0	$21.00
	D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$0	$0	$0	$0	$15.00
	D0150		Comprehensive oral evaluation - new or established patient	$0	$0	$0	$0	$21.00
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0	$0	$0	$0	$0.00
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0	$0	$0	$0	$15.00
	D0171		Re-evaluation - post operative office visit	$0	$0	$0	$0	$0.00
	D0180		Comprehensive periodontal evaluation - new or established patient	$0	$0	$0	$0	$21.00
	D0190		Screening of a patient	$0	$0	$0	$0	$0.00
	D0191		Assessment of a patient	$0	$0	$0	$0	$0.00
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)								
	D0210		Intraoral - complete series of radiographic images	$0	$0	$0	$0	$0.00
	D0220		Intraoral - periapical radiographic image	$0	$0	$0	$0	$0.00
	D0230		Intraoral - periapical each additional film	$0	$0	$0	$0	$0.00
	D0240		Intraoral - occlusal radiographic	$0	$0	$0	$0	$0.00
	D0250		Extra-oral single film	$0	$0	$0	$0	$0.00
	D0270		Bitewing - single film	$0	$0	$0	$0	$0.00
	D0272		Bitewings - two films	$0	$0	$0	$0	$0.00
	D0273		Bitewings - three films	$0	$0	$0	$0	$0.00
	D0274		Bitewings - four films	$0	$0	$0	$0	$0.00
	D0277		Vertical bitewings - 7 to 8 films	$0	$0	$0	$0	$0.00
	D0330		Panoramic film	$0	$0	$0	$0	$0.00
	D0340		Cephalometric Film	$0	$0	$0	$0	$0.00
	D0350		Oral/Facial Images	$0	$0	$0	$0	$0.00
TESTS AND EXAMINATIONS								
	D0419		Assement of salivary flow by measurement	$0	$0	$0	$0	$0.00
	D0460		Pulp vitality tests	$0	$0	$0	$0	$0.00
	D0470		Diagnostic casts	$0	$0	$0	$0	$0.00
	D0601		Caries risk assessment and documentation, with a finding of low risk	$0	$0	$0	$0	$0.00
	D0602		Caries risk assessment and documentation, with a finding of moderate risk	$0	$0	$0	$0	$0.00
	D0603		Caries risk assessment and documentation, with a finding of high risk	$0	$0	$0	$0	$0.00
	D0701		Panoramic radiographic image- image capture only	$0	$0	$0	$0	$0.00
	D0702		2-D cephalometric radiographic- image capture only	$0	$0	$0	$0	$0.00
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0	$0	$0	$0	$0.00
	D0705		extra-oral posterior dental radiographic image capture only	$0	$0	$0	$0	$0.00
	D0706		intraoral- occlusal radiographic image- image capture only	$0	$0	$0	$0	$0.00
	D0707		intraoral- periapical radiographic image- image capture only	$0	$0	$0	$0	$0.00
	D0708		intraoral- bitewing radiographic image- image capture only	$0	$0	$0	$0	$0.00
	D0709		intraoral- complete series of radiographic images- image capture only	$0	$0	$0	$0	$0.00
ORAL PATHOLOGY LABORATORY								
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0	$0	$0	$0	$0.00
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0	$0	$0	$0	$0.00
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0	$0	$0	$0	$0.00
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0	$0	$0	$0	$0.00
DENTAL PROPHYLAXIS								
	D1110		Prophylaxis - adult	$0	$0	$0	$0	$40.00
			D1110 and D1120 additional prophy exceeding two in a 12 month period	$0	$20	$30	$40	$40.00
	D1120		Prophylaxis - child	$0	$0	$0	$0	$30.00
			D1110 and D1120 additional prophy exceeding two in a 12 month	$0	$15	$20	$25	$25.00
TOPICAL FLUORIDE TREATMENT (office procedure)								
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0	$0	$0	$0	$12.00
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0	$0	$0	$0	$10.00
OTHER PREVENTIVE SERVICES								
	D1310		Nutritional Counseling for control of dental disease	$0	$0	$0	$0	$0.00

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	D1320		Tobacco counseling for the control and prevention of oral disease	$0	$0	$0	$0	$0.00
	D1330		Oral hygiene instructions	$0	$0	$0	$0	$0.00
	D1351		Sealant - per tooth	$0	$0	$0	$0	$25.00
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0	$0	$0	$0	$22.00
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0	$0	$0	$0	$22.00
	D1354		Interim caries arresting medicament application - per tooth	$0	$0	$0	$0	$0.00
	D1355		caries preventive medicament application - per tooth	$0	$0	$0	$0	$0.00
SPACE MAINTENANCE (passive appliances)								
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0	$0	$10	$20	$145.00
	D1516		Space maintainer - fixed - bilateral - maxillary	$0	$0	$15	$30	$145.00
	D1517		Space maintainer - fixed - bilateral - mandibular	$0	$0	$15	$30	$145.00
	D1520		Space maintainer - removable - unilateral	$0	$0	$15	$30	$125.00
	D1526		Space maintainer - removable - maxillary	$0	$0	$20	$35	$125.00
	D1527		Space maintainer - removable - mandibular	$0	$0	$20	$35	$125.00
	D1551		Re-cement or re-bond bilateral space maintainer	$0	$0	$0	$0	$25.00
	D1552		Re-cement or re-bond unilateral space maintainer	$0	$0	$0	$0	$25.00
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0	$0	$0	$0	$25.00
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0	$0	$5	$10	$25.00
	D1557		Removal of fixed bilateral space maintainer maxillary	$0	$0	$5	$10	$25.00
	D1558		Removal of fixed bilateral space maintainer mandibular	$0	$0	$5	$10	$25.00
	D1575		Distal shoe space maintainer - fixed unilateral	$0	$0	$15	$30	$30.00
AMALGAM RESTORATIONS (including polishing)								
	D2140		Amalgam - one surface, primary or permanent	$0	$0	$0	$0	$41.00
	D2150		Amalgam - two surfaces, primary or permanent	$0	$0	$0	$0	$52.00
	D2160		Amalgam - three surfaces, primary or permanent	$0	$0	$0	$0	$61.00
	D2161		Amalgam - four or more surfaces, primary or permanent	$0	$0	$0	$0	$73.00
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT								
	D2330		Resin-based composite - one surface, anterior	$0	$0	$0	$0	$65.00
	D2331		Resin-based composite - two surfaces, anterior	$0	$0	$0	$0	$70.00
	D2332		Resin-based composite - three surfaces, anterior	$0	$0	$0	$0	$75.00
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0	$0	$0	$0	$94.00
	D2390		Resin-based composite crown, anterior	$0	$0	$0	$0	$50.00
	D2391		Resin-based composite - one surface, posterior	$0	$0	$10	$15	$65.00
	D2392		Resin-based composite - two surfaces, posterior	$0	$0	$15	$20	$81.00
	D2393		Resin-based composite - three surfaces, posterior	$0	$0	$20	$25	$105.00
	D2394		Resin-based composite - four or more surfaces, posterior	$0	$0	$30	$35	$125.00
INLAY/ONLAY RESTORATIONS								
	D2510		Inlay - metallic - one surface	$0	$0	$0	$50	$275.00
	D2520		Inlay - metallic - two surfaces	$0	$0	$0	$60	$335.00
	D2530		Inlay - metallic - three or more surfaces	$0	$0	$0	$60	$370.00
	D2542		Onlay - metallic - two surfaces	$0	$0	$0	$65	$388.00
	D2543		Onlays - metallic - three surfaces	$0	$0	$0	$65	$406.00
	D2544		Onlays - metallic - four or more surfaces	$0	$0	$0	$70	$422.00
	D2610		Inlay - porcelain/ceramic - 1 surface	$0	$185	$245	$330	$356.00
	D2620		Inlay - porcelain/ceramic - 2 surfaces	$0	$195	$260	$345	$376.00
	D2630		Inlay - porcelain/ceramic - 3 or more surfaces	$0	$205	$275	$365	$400.00
	D2642		Onlay, porcelain/ceramic - 2 surfaces	$0	$200	$270	$355	$388.00
	D2643		Onlay, porcelain/ceramic - 3 surfaces	$0	$215	$290	$385	$406.00
	D2651		Inlay - resin-based composite - 2 surfaces	$0	$145	$190	$255	$255.00
	D2652		Inlay - resin-based composite - 3 or more surfaces	$0	$150	$200	$270	$270.00
	D2662		Onlay - resin-based composite - 2 surfaces	$0	$135	$175	$235	$235.00
	D2663		Onlay - resin-based composite - 3 surfaces	$0	$155	$205	$275	$275.00
CROWNS - SINGLE RESTORATIONS ONLY								
	D2710		Crown - resin-based composite (indirect)	$0	$0	$25	$45	$45.00
	D2712		Crown - 3/4 resin-based composite (indirect)	$0	$0	$25	$45	$45.00
	D2720		Crown - resin with high noble metal	$0	$35	$50	$125	$125.00
	D2721		Crown - resin with predominantly base metal	$0	$35	$50	$125	$125.00
	D2722		Crown - resin with noble metal	$0	$35	$50	$125	$125.00
	D2740		Crown - porcelain/ceramic	$0	$55	$70	$130	$550.00
	D2750		Crown - porcelain fused to high noble metal	$0	$40	$55	$125	$500.00
	D2751		Crown - porcelain fused to predominantly base metal	$0	$35	$45	$65	$500.00
	D2752		Crown - porcelain fused to noble metal	$0	$55	$65	$75	$500.00
	D2753		Crown- porcelain fused to titanium or titanium alloy	$0	$55	$65	$75	$500.00
	D2780		Crown - 3/4 cast high noble metal	$0	$45	$60	$125	$432.00

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	D2781		Crown - 3/4 cast predominantly base metal	$0	$40	$60	$125	$407.00
	D2782		Crown - 3/4 cast noble metal	$0	$40	$60	$125	$420.00
	D2783		Crown - 3/4 porcelain/ceramic	$0	$40	$60	$130	$445.00
	D2790		Crown - full cast high noble metal	$0	$45	$50	$125	$500.00
	D2791		Crown - full cast predominantly base metal	$0	$45	$50	$125	$500.00
	D2792		Crown - full cast noble metal	$0	$45	$50	$125	$500.00
	D2794		Crown - titanium	$0	$60	$70	$125	$500.00
	D2799		Provisional crown - To be used at least 6 months during healing	$0	$0	$15	$30	$0.00
OTHER RESTORATIVE SERVICES								
	D2910		Recement inlay, onlay, or partial coverage restoration	$0	$0	$0	$5	$30.00
	D2915		Recement cast or prefabricated post and core	$0	$0	$0	$5	$10.00
	D2920		Recement crown	$0	$0	$0	$5	$30.00
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0	$0	$15	$20	$40.00
	D2930		Prefabricated stainless steel crown - primary tooth	$0	$0	$10	$20	$90.00
	D2931		Prefabricated stainless steel crown - permanent tooth	$0	$0	$15	$25	$100.00
	D2932		Prefabricated resin crown	$0	$0	$15	$30	$95.00
	D2933		Prefabricated stainless steel crown with resin window	$0	$0	$15	$30	$130.00
	D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$0	$0	$15	$30	$35.00
	D2940		Sedative filling	$0	$0	$0	$0	$34.00
	D2950		Core buildup, involving and including any pins	$0	$0	$10	$15	$25.00
	D2951		Pin retention - per tooth, in addition to restoration	$0	$0	$0	$0	$25.00
	D2952		Post and core in addition to crown, indirectly fabricated	$0	$0	$10	$20	$133.00
	D2953		Each additional indirectly fabricated post - same tooth	$0	$0	$10	$10	$25.00
	D2954		Prefabricated post and core in addition to crown	$0	$0	$10	$20	$105.00
	D2955		Post removal (not in conjunction with endodontic therapy)	$0	$0	$0	$0	$25.00
	D2957		Each additional prefabricated post - same tooth	$0	$0	$10	$10	$25.00
	D2962		Labial veneer - porcelain laminate (laboratory)	$0	$600	$600	$600	$285.00
			Rebond Veneer	$0	$80	$80	$80	$80.00
	D2971		Additional procedures to construct new crown under existing partial denture framework	$0	$0	$15	$25	$25.00
	D2980		Crown repair, by report	$0	$0	$0	$0	$20.00
PULP CAPPING								
	D3110		Pulp cap - direct (excluding final restoration)	$0	$0	$0	$0	$28.00
	D3120		Pulp cap - indirect (excluding final restoration)	$0	$0	$0	$0	$35.00
PULPOTOMY								
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0	$0	$5	$10	$55.00
	D3221		Pulpal debridement, primary and permanent teeth	$0	$0	$5	$10	$25.00
ENDODONTIC THERAPY ON PRIMARY TEETH								
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0	$0	$10	$15	$45.00
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0	$0	$10	$15	$71.00
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)								
	D3310		Anterior (excluding final restoration)	$0	$0	$20	$40	$250.00
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$0	$0	$30	$60	$310.00
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$0	$0	$40	$75	$400.00
	D3331		Treatment of root canal obstruction; non-surgical access	$0	$40	$55	$65	$150.00
	D3332		Incomplete endodontic theraph;inoperable, unrestorable or fracture tooth	$0	$45	$50	$75	$100.00
	D3333		Internal root repair of perforation defects	$0	$55	$55	$85	$125.00
ENDODONTIC RETREATMENT								
	D3346		Retreatment of previous root canal therapy - anterior	$0	$0	$25	$45	$338.00
	D3347		Retreatment of previous root canal therapy - premolar	$0	$0	$30	$60	$403.00
	D3348		Retreatment of previous root canal therapy - molar	$0	$0	$50	$95	$484.00
APEXIFICATION / RECALCIFICATION								
APICOECTOMY/PERIRADICULAR SERVICES								
	D3410		Apicoectomy- anterior	$0	$0	$25	$45	$275.00
	D3421		Apicoectomy premolar (first root)	$0	$0	$25	$45	$356.00
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0	$0	$25	$45	$375.00
	D3426		Apicoectomy (each additional root)	$0	$0	$10	$20	$115.00
	D3428		Bone graft in conjunction with periradicular surgery - per tooth, single site	$0	$150	$160	$170	$150.00
	D3429		Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$0	$95	$105	$115	$95.00
	D3430		Retrograde filling - per root	$0	$0	$0	$0	$25.00
	D3450		Root amputation - per root	$0	$0	$0	$0	$170.00
	D3471		Surgical repair of root resorption-anterior	$0	$0	$25	$45	$50.00
	D3472		Surgical repair of root resorption-premolar	$0	$0	$25	$45	$50.00

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	D3473		Surgical repair of root resorption-molar	$0	$0	$25	$45	$50.00
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0	$0	$35	$55	$50.00
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0	$0	$45	$65	$50.00
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0	$0	$60	$80	$50.00
OTHER ENDODONTIC PROCEDURES								
	D3910		Surgical procedure for isolation of tooth with rubber dam	$0	$0	$0	$0	$0.00
	D3920		Hemisection (including any root removal), not including root canal therapy	$0	$0	$15	$25	$140.00
	D3950		Canal preparation and fitting of preformed dowel or post	$0	$0	$0	$0	$0.00
SURGICAL SERVICES (including usual postoperative care)								
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$10	$20	$180.00
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$10	$15	$60.00
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$15	$30	$190.00
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$10	$20	$105.00
	D4245		Apically positioned flap	$0	$0	$20	$40	$20.00
	D4249		Clinical crown lengthening - hard tissue	$0	$0	$25	$45	$200.00
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$60	$115	$320.00
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$0	$0	$10	$20	$171.00
	D4263		Bone replacement graft - first site in quadrant	$0	$0	$50	$95	$50.00
	D4264		Bone replacement graft - each additional site in quadrant	$0	$0	$40	$75	$40.00
	D4274		Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0	$0	$15	$30	$20.00
NON-SURGICAL PERIODONTAL SERVICES								
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0	$0	$10	$15	$75.00
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0	$0	$5	$5	$41.00
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0	$0	$0	$0	$50.00
	D4355		Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit	$0	$0	$10	$15	$67.00
	D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (up to 2 teeth per quad)	$0	$0	$20	$35	$35.00
OTHER PERIODONTAL SERVICES								
	D4910		Periodontal maintenance	$0	$0	$15	$25	$60.00
	D4921		Gingival Irrigation - Per Quadrant	$0	$0	$10	$20	$20.00
COMPLETE DENTURES (including routine post-delivery care)								
	D5110		Complete denture - maxillary	$0	$175	$225	$275	$650.00
	D5120		Complete denture - mandibular	$0	$175	$225	$275	$650.00
	D5130		Immediate denture - maxillary	$0	$185	$200	$300	$650.00
	D5140		Immediate denture - mandibular	$0	$185	$200	$300	$650.00
PARTIAL DENTURES (including routine post-delivery care)								
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0	$0	$40	$75	$425.00
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$0	$0	$40	$75	$425.00
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$0	$0	$60	$115	$750.00
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0	$0	$60	$115	$750.00
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0	$0	$40	$75	$750.00
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$0	$0	$40	$75	$750.00
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$0	$0	$60	$115	$750.00
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$0	$0	$60	$115	$750.00
	D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$0	$0	$60	$115	$750.00
	D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$0	$0	$60	$115	$750.00

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	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$0	$0	$45	$85	$150.00
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$0	$0	$45	$85	$150.00
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$0	$0	$45	$85	$150.00
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$0	$0	$45	$85	$150.00
ADJUSTMENTS TO DENTURES								
	D5410		Adjust complete denture - maxillary	$0	$0	$5	$10	$30.00
	D5411		Adjust complete denture - mandibular	$0	$0	$5	$10	$30.00
	D5421		Adjust partial denture - maxillary	$0	$0	$5	$10	$30.00
	D5422		Adjust partial denture - mandibular	$0	$0	$5	$10	$30.00
REPAIRS TO COMPLETE DENTURES								
	D5511		Repair broken complete denture base, mandibular	$0	$0	$10	$15	$40.00
	D5512		Repair broker complete denture base, maxillary	$0	$0	$10	$15	$40.00
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0	$0	$10	$15	$50.00
REPAIRS TO PARTIAL DENTURES								
	D5611		Repair resin partial denture base, mandibular	$0	$0	$10	$15	$20.00
	D5612		Repair resin partial denture base, maxillary	$0	$0	$10	$15	$20.00
	D5621		Repair cast partial framework, mandibular	$0	$0	$10	$15	$40.00
	D5622		Repair cast partial framework, maxillary	$0	$0	$10	$15	$40.00
	D5630		Repair or replace broken clasp- per tooth	$0	$0	$10	$15	$50.00
	D5640		Replace broken teeth - per tooth	$0	$0	$10	$15	$50.00
	D5650		Add tooth to existing partial denture	$0	$0	$10	$15	$65.00
	D5660		Add clasp to existing partial denture - per tooth	$0	$0	$10	$15	$80.00
	D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	$0	$0	$40	$75	$190.00
	D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	$0	$0	$40	$75	$190.00
DENTURE REBASE PROCEDURES								
	D5710		Rebase complete maxillary denture	$0	$0	$15	$30	$250.00
	D5711		Rebase complete mandibular denture	$0	$0	$15	$30	$250.00
	D5720		Rebase maxillary partial denture	$0	$0	$15	$30	$250.00
	D5721		Rebase mandibular partial denture	$0	$0	$15	$30	$250.00
DENTURE RELINE PROCEDURES								
	D5730		Reline complete maxillary denture (chairside)	$0	$0	$10	$15	$110.00
	D5731		Reline complete mandibular denture (chairside)	$0	$0	$10	$15	$110.00
	D5740		Reline maxillary partial denture (chairside)	$0	$0	$10	$15	$110.00
	D5741		Reline mandibular partial denture (chairside)	$0	$0	$10	$15	$110.00
	D5750		Reline complete maxillary denture (laboratory)	$0	$0	$15	$30	$175.00
	D5751		Reline complete mandibular denture (laboratory)	$0	$0	$15	$30	$175.00
	D5760		Reline maxillary partial denture (laboratory)	$0	$0	$15	$30	$175.00
	D5761		Reline mandibular partial denture (laboratory)	$0	$0	$15	$30	$175.00
OTHER REMOVABLE PROSTHETIC SERVICES								
	D5810		Interim complete denture (maxillary)	$0	$0	$75	$150	$100.00
	D5811		Interim complete denture (mandibular)	$0	$0	$75	$150	$100.00
	D5820		Interim partial denture (maxillary)	$0	$0	$30	$60	$185.00
	D5821		Interim partial denture (mandibular)	$0	$0	$30	$60	$185.00
	D5850		Tissue conditioning, maxillary	$0	$0	$10	$20	$50.00
	D5851		Tissue conditioning, mandibular	$0	$0	$10	$20	$50.00
IMPLANT SERVICES								
	D6010		Surgical placement of implant body: endosteal implant	$1,400	$1,400	$1,400	$1,400	$0.00
	D6058		Abutment supported porcelain/ceramic crown	$960	$960	$960	$960	$0.00
	D6059		Abutment supported porcelain fused to metal crown (high noble metal)	$965	$965	$965	$965	$0.00
	D6060		Abutment supported porcelain fused to metal crown (predominantly base metal)	$915	$915	$915	$915	$0.00
	D6061		Abutment supported porcelain fused to metal crown (noble metal)	$930	$930	$930	$930	$0.00
	D6062		Abutment supported cast metal crown (high noble metal)	$925	$925	$925	$925	$0.00
	D6063		Abutment supported cast metal crown (predominantly base metal)	$800	$800	$800	$800	$0.00
	D6064		Abutment supported cast metal crown (noble metal)	$840	$840	$840	$840	$0.00
	D6065		Implant supported porcelain/ceramic crown	$955	$955	$955	$955	$0.00
	D6066		Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935	$935	$935	$935	$0.00
	D6067		Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910	$910	$910	$910	$0.00
	D6068		Abutment supported retainer for porcelain/ceramic FPD	$975	$975	$975	$975	$0.00

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	ADA CODE		* ADA DESCRIPTION	8000	8001	8002	8003	Minimum Guarantee Schedule
CAPITATION (Per Member)				**$ 2.50**	**$ 2.50**	**$ 2.50**	**$ 2.50**	
	D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965	$965	$965	$965	$0.00
	D6070		Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915	$915	$915	$915	$0.00
	D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930	$930	$930	$930	$0.00
	D6072		Abutment supported retainer for cast metal FPD (high noble metal)	$950	$950	$950	$950	$0.00
	D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	$860	$860	$860	$860	$0.00
	D6074		Abutment supported retainer for cast metal FPD (noble metal)	$925	$925	$925	$925	$0.00
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0	$0	$5	$5	$0.00
	D6094		Abutment supported crown - (titanium)	$600	$600	$600	$600	$0.00
	D6191		Semi-precision abutment - placement	$600	$600	$600	$600	$0.00
	D6192		Semi-precision attachment - placement	$600	$600	$60	$600	$0.00
	D6194		Abutment supported retainer crown for FPD (titanium)	$500	$500	$500	$500	$0.00
	D6195		Abutment supported retainer - porcelain fused to titanium or titanium alloy	$0	$0	$45	$90	$0.00
FIXED PARTIAL DENTURE PONTICS								
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$0	$0	$50	$100	$350.00
	D6210		Pontic - cast high noble metal	$0	$35	$50	$125	$410.00
	D6211		Pontic - cast predominantly base metal	$0	$35	$50	$125	$410.00
	D6212		Pontic - cast noble metal	$0	$35	$50	$125	$410.00
	D6214		Pontic - titanium	$0	$60	$70	$125	$410.00
	D6240		Pontic - porcelain fused to high noble metal	$0	$55	$70	$130	$410.00
	D6241		Pontic - porcelain fused to predominantly base metal	$0	$55	$70	$130	$410.00
	D6242		Pontic - porcelain fused to noble metal	$0	$55	$70	$130	$410.00
	D6243		Pontic - porcelain fused to titanium or titanium alloys	$0	$55	$65	$75	$410.00
	D6245		Pontic - porcelain/ceramic	$0	$55	$65	$75	$325.00
	D6250		Pontic - resin with high noble metal	$0	$35	$50	$125	$410.00
	D6251		Pontic - resin with predominantly base metal	$0	$35	$50	$125	$325.00
	D6252		Pontic - resin with noble metal	$0	$35	$50	$125	$410.00
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS								
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$0	$0	$35	$70	$200.00
FIXED PARTIAL DENTURE RETAINERS - CROWNS								
	D6710		Crown - indirect resin based composite	$0	$0	$50	$100	$500.00
	D6720		Crown - resin with high noble metal	$0	$35	$50	$125	$500.00
	D6721		Crown - resin with predominantly base metal	$0	$35	$50	$125	$500.00
	D6722		Crown - resin with noble metal	$0	$35	$50	$125	$500.00
	D6740		Crown - porcelain/ceramic	$0	$55	$70	$130	$550.00
	D6750		Crown - porcelain fused to high noble metal	$0	$40	$55	$125	$500.00
	D6751		Crown - porcelain fused to predominantly base metal	$0	$35	$45	$65	$500.00
	D6752		Crown - porcelain fused to noble metal	$0	$55	$65	$75	$500.00
	D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$0	$55	$65	$75	$500.00
	D6780		Crown - 3/4 cast high noble metal	$0	$45	$60	$125	$500.00
	D6781		Crown - 3/4 cast predominantly base metal	$0	$40	$60	$125	$500.00
	D6782		Crown - 3/4 cast noble metal	$0	$40	$60	$125	$500.00
	D6783		Crown - 3/4 cast porcelain/ceramic	$0	$40	$60	$130	$500.00
	D6784		Retainer crown 3/4 - titaninium and titanium alloys	$0	$60	$70	$80	$500.00
	D6790		Crown - full cast high noble metal	$0	$45	$50	$125	$500.00
	D6791		Crown - full cast predominantly base metal	$0	$45	$50	$125	$500.00
	D6792		Crown - full cast noble metal	$0	$45	$50	$125	$500.00
	D6794		Crown - titanium	$0	$60	$70	$125	$500.00
OTHER FIXED PARTIAL DENTURE SERVICES								
	D6930		Recement fixed partial denture	$0	$0	$0	$0	$52.00
	D6940		Stress breaker	$0	$0	$45	$85	$180.00
	D6980		Fixed partial denture repair, by report	$0	$0	$0	$0	$20.00
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)								
	D7111		Extraction, coronal remnants - primary tooth	$0	$0	$5	$15	$46.00
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0	$0	$10	$20	$61.00
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)								
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0	$0	$5	$15	$90.00
	D7220		Removal of impacted tooth - soft tissue	$0	$0	$20	$40	$120.00
	D7230		Removal of impacted tooth - partially bony	$0	$0	$25	$45	$160.00
	D7240		Removal of impacted tooth - completely bony	$0	$0	$35	$70	$195.00

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	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$0	$0	$35	$70	$205.00
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0	$0	$35	$70	$96.00
OTHER SURGICAL PROCEDURES								
	D7270		Tooth reimplantation and/or stabilization of accidentally evulsed o	$0	$0	$95	$190	$174.00
	D7280		Surgical access of an unerupted tooth	$0	$0	$10	$15	$80.00
	D7283		Placement of device to facilitate eruption of impacted tooth	$0	$0	$5	$5	$135.00
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0	$0	$20	$40	$95.00
	D7286		Biopsy of oral tissue - soft (all others)	$0	$0	$20	$40	$108.00
	D7288		Brush biopsy - transepithelial sample collection	$0	$0	$20	$40	$50.00
ALVEOLOPLASTY (surgical preparation of ridge for dentures)								
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0	$0	$10	$15	$50.00
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0	$0	$5	$10	$50.00
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0	$0	$10	$15	$50.00
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0	$0	$5	$10	$50.00
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS								
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0	$0	$20	$40	$150.00
EXCISION OF BONE TISS		**U**						
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0	$0	$115	$225	$263.00
	D7485		Surgical reduction of osseous tuberosity	$0	$0	$115	$225	$75.00
SURGICAL INCISION								
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0	$0	$10	$15	$50.00
	D7520		Incision and drainage of abscess - extraoral soft tissue	$0	$0	$15	$25	$362.00
OTHER REPAIR PROCEDURES								
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0	$0	$0	$0	$0.00
	D7953		Bone replacement graft for ridge preservation - per site	$0	$100	$200	$300	$250.00
	D7961		buccal/labial frenectomy	$0	$0	$10	$20	$35.00
	D7962		lingual frenectomy	$0	$0	$10	$20	$25.00
	D7963		Frenuloplasty	$0	$0	$10	$15	$25.00
	D7970		Excision of hyperplastic tissue - per arch	$0	$0	$15	$30	$100.00
	D7971		Excision of pericoronal gingiva	$0	$0	$10	$15	$60.00
COMPREHENSIVE ORTHODONTIC TREATMENT								
	D8010		Limited orthodontic treatment of the primary dentition	$800	$800	$800	$800	$0.00
	D8020		Limited orthodontic treatment of the transitional dentition	$800	$800	$800	$800	$0.00
	D8030		Limited orthodontic treatment of the adolescent dentition	$800	$800	$800	$800	$0.00
	D8040		Limited orthodontic treatment of the adult dentition	$800	$800	$800	$800	$0.00
	D8050		Interceptive orthodontic treatment of the primary dentition	$950	$950	$950	$950	$0.00
	D8060		Interceptive orthodontic treatment of the transitional dentition	$950	$950	$950	$950	$0.00
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,600	$1,600	$1,600	$1,600	$0.00
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,600	$1,600	$1,600	$1,600	$2,000.00
	D8090		Comprehensive orthodontic treatment of the adult dentition	$2,100	$2,100	$2,100	$2,100	$2,500.00
OTHER ORTHODONTIC SERVICES								
			Orthodontic material upgrade - gold or clear brackets	$210	$210	$210	$210	$0.00
			Invisalign or any similar product	$350	$350	$350	$350	$0.00
	D8660		Pre-orthodontic treatment visit	$0	$0	$0	$0	$50.00
	D8670		Periodic orthodontic treament visit	$50	$50	$60	$70	$0.00
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250	$250	$250	$250	$0.00
	D8681		Removable orthodontic retainer adjustment	$50	$50	$50	$50	$0.00
	D8999		Orthodontic records fee	$275	$275	$275	$275	$0.00
UNCLASSIFIED TREATMENT								
	D9110		Palliative (emergency) treatment of dental pain - minor procedure	$0	$0	$5	$10	$35.00
ANESTHESIA								
	D9210		Local anesthesia not in conjunction with operative or surgical procedures	$0	$0	$0	$0	$0.00
	D9211		Regional block anesthesia	$0	$0	$0	$0	$0.00
	D9212		Trigeminal division block anesthesia	$0	$0	$0	$0	$0.00
	D9215		Local anesthesia	$0	$0	$0	$0	$0.00
	D9222		Deep sedation/general anesthesia - first 15 minutes	$0	$0	$75	$150	$125.00
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$0	$0	$75	$150	$125.00
	D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$0	$0	$15	$30	$25.00
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$0	$0	$70	$135	$100.00

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	D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$0	$0	$70	$135	$100.00
PROFESSIONAL CONSULTATION								
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0	$0	$0	$0	$40.00
PROFESSIONAL VISITS								
	D9430		Office visit for observation (during regularly scheduled hours) - no other services performed	$0	$0	$0	$0	$22.00
	D9440		Office visit, after regularly scheduled hours	$0	$0	$15	$30	$45.00
MISCELLANEOUS SERVICES								
	D9910		Application of desensitizing medicament	$0	$0	$10	$20	$43.00
	D9932		Cleaning and inspection of removable complete denture, maxillar	$0	$0	$0	$0	$0.00
	D9933		Cleaning and inspection of removable complete denture, mandibu	$0	$0	$0	$0	$0.00
	D9934		Cleaning and inspection of removable partial denture maxillary	$0	$0	$0	$0	$0.00
	D9935		Cleaning and inspection of removable partial denture, mandibular	$0	$0	$0	$0	$0.00
	D9944		Occlusal guard - hard appliance, full arch	$0	$0	$75	$150	$150.00
	D9945		Occlusal guard - soft appliance, full arch	$0	$0	$75	$150	$150.00
	D9946		Occlusal guard - hard appliance, partial arch	$0	$0	$75	$150	$150.00
	D9951		Occlusal adjustment - limited	$0	$0	$5	$10	$0.00
	D9952		Occlusal adjustment - complete	$0	$0	$15	$30	$0.00
	D9972		External bleaching - per arch - take home trays	$0	$100	$100	$100	$100.00
	D9975		External bleaching for home application, per arch; includes materials and fabrication of custom trays	$0	$100	$100	$100	$100.00
NON CLINICAL PROCEDURES								
	D9986		Missed appointment	$0	$0	$0	$0	$0.00
	D9987		Cancelled appointment	$0	$0	$0	$0	$0.00
	D9990		Certified Translation or Sign Language Services - per visit	$0	$0	$0	$0	$0.00
	D9997		Dental case management - patients with special health care needs	$0	$0	$0	$0	$0.00

LIMITATIONS & EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits:

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial
Images- once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered subject to the determination of the treating provider are:

1) Pregnancy,
2) Pre-radiation therapy as ordered by an oncologist,
3) Gingival hyperplasia due to the use of Dilantin or other medications,
4) Inflammation due to syphilis or tuberculosis,
5) Chronic menopausal gingivostomatitis,
6) Leukemia or HIV induced gingivitis.

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to two (2) treatments in a 12 consecutive month period.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Use of precious metal in fabrication of a crown, inlay or onlay is considered elective and an additional metal charge will apply.

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one (1) per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one (1) per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve (12) months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable.

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the arch in accordance with professionally recognized standards of dental practice.

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture.

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit.

The Plan provides coverage for up to six units for crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

LIMITATIONS & EXCLUSIONS

ORTHODONTIC COVERAGES

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

LIMITATIONS & EXCLUSIONS

EXCLUSIONS

The following dental procedures and services are excluded from this coverage by the Benefit Plan:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services

Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect.

Crowns and pontics supported on a dental implant.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Implant supported dentures, unless specifically listed as a covered benefit under your plan.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Implant supported bridges, unless specifically listed as a covered benefit under your plan.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided.
Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

Appliances to correct and control harmful habits (e.g. tongue thrust and thumb sucking).

SPECIAL GROUP PLANS

This section contains the various custom group plans created by Western Dental for specific groups. For each special group plan, member co-payments are listed with plan limitations and exclusions.

8000C3

Schedule of Benefits

ADA Code			*ADA Description	8000C3
CLINICAL ORAL EVALUATIONS				
	D0120		Periodic oral examination - established patient	$0
	D0140		Limited oral evaluation - problem focused	$0
	D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
	D0150		Comprehensive oral evaluation - new or established patient	$0
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
	D0171		Re-evaluation - post operative office visit	$0
	D0180		Comprehensive periodontal evaluation - new or established patient	$0
	D0190		Screening of a patient	$0
	D0191		Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)				
	D0210		Intraoral comprehensive series of radiographic images	$0
	D0220		Intraoral - periapical radiographic image	$0
	D0230		Intraoral - periapical each additional film	$0
	D0240		Intraoral - occlusal radiographic	$0
	D0250		Extra-oral single film	$0
	D0270		Bitewing - single film	$0
	D0272		Bitewings - two films	$0
	D0273		Bitewings - three films	$0
	D0274		Bitewings - four films	$0
	D0277		Vertical bitewings - 7 to 8 films	$0
	D0330		Panoramic film	$0
	D0340		Cephalometric Film	$0
	D0350		Oral/Facial Images	$0
TESTS AND EXAMINATIONS				
	D0419		Assement of salivary flow by measurement	$0
	D0460		Pulp vitality tests	$0
	D0470		Diagnostic casts	$0
	D0601		Caries risk assessment and documentation, with a finding of low risk	$0
	D0602		Caries risk assessment and documentation, with a finding of moderate risk	$0
	D0603		Caries risk assessment and documentation, with a finding of high risk	$0
	D0701		Panoramic radiographic image- image capture only	$0
	D0702		2-D cephalometric radiographic- image capture only	$0
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
	D0705		extra-oral posterior dental radiographic image capture only	$0

	ADA Code		*ADA Description	8000C3
	D0706		intraoral- occlusal radiographic image- image capture only	$0
	D0707		intraoral- periapical radiographic image- image capture only	$0
	D0708		intraoral- bitewing radiographic image- image capture only	$0
	D0709		intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY				
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - adult	$0
			D1110 and D1120 additional prophy exceeding two in a 12 month period (limit 3 per year)	$0
	D1120		Prophylaxis - child	$0
			D1110 and D1120 additional prophy exceeding three in a 12 month	$0
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1320		Tobacco counseling for the control and prevention of oral disease	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
	D1355		caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0

	ADA Code		*ADA Description	8000C3
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0
	D1557		Removal of fixed bilateral space maintainer maxillary	$0
	D1558		Removal of fixed bilateral space maintainer mandibular	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-based composite - one surface, posterior	$0
	D2392		Resin-based composite - two surfaces, posterior	$0
	D2393		Resin-based composite - three surfaces, posterior	$0
	D2394		Resin-based composite - four or more surfaces, posterior	$0
INLAY/ONLAY RESTORATIONS				
	D2510		Inlay - metallic - one surface	$0
	D2520		Inlay - metallic - two surfaces	$0
	D2530		Inlay - metallic - three or more surfaces	$0
	D2542		Onlay - metallic - two surfaces	$0
	D2543		Onlays - metallic - three surfaces	$0
	D2544		Onlays - metallic - four or more surfaces	$0
	D2610		Inlay - porcelain/ceramic - 1 surface	$0
	D2620		Inlay - porcelain/ceramic - 2 surfaces	$0
	D2630		Inlay - porcelain/ceramic - 3 or more surfaces	$0
	D2642		Onlay, porcelain/ceramic - 2 surfaces	$0
	D2643		Onlay, porcelain/ceramic - 3 surfaces	$0
	D2651		Inlay - resin-based composite - 2 surfaces	$0
	D2652		Inlay - resin-based composite - 3 or more surfaces	$0
	D2662		Onlay - resin-based composite - 2 surfaces	$0
	D2663		Onlay - resin-based composite - 3 surfaces	$0
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect)	$0

	ADA Code		*ADA Description	8000C3
	D2712		Crown - 3/4 resin-based composite (indirect)	$0
	D2720		Crown - resin with high noble metal	$0
	D2721		Crown - resin with predominantly base metal	$0
	D2722		Crown - resin with noble metal	$0
	D2740		Crown - porcelain/ceramic	$0
	D2750		Crown - porcelain fused to high noble metal	$0
	D2751		Crown - porcelain fused to predominantly base metal	$0
	D2752		Crown - porcelain fused to noble metal	$0
	D2753		Crown- porcelain fused to titanium or titanium alloy	$0
	D2780		Crown - 3/4 cast high noble metal	$0
	D2781		Crown - 3/4 cast predominantly base metal	$0
	D2782		Crown - 3/4 cast noble metal	$0
	D2783		Crown - 3/4 porcelain/ceramic	$0
	D2790		Crown - full cast high noble metal	$0
	D2791		Crown - full cast predominantly base metal	$0
	D2792		Crown - full cast noble metal	$0
	D2794		Crown - titanium	$0
	D2799		Provisional crown - To be used at least 6 months during healing	$0
OTHER RESTORATIVE SERVICES				
	D2910		Recement inlay, onlay, or partial coverage restoration	$0
	D2915		Recement cast or prefabricated post and core	$0
	D2920		Recement crown	$0
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2930		Prefabricated stainless steel crown - primary tooth	$0
	D2931		Prefabricated stainless steel crown - permanent tooth	$0
	D2932		Prefabricated resin crown	$0
	D2933		Prefabricated stainless steel crown with resin window	$0
	D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$0
	D2940		Sedative filling	$0
	D2950		Core buildup, involving and including any pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post and core in addition to crown, indirectly fabricated	$0
	D2953		Each additional indirectly fabricated post - same tooth	$0
	D2954		Prefabricated post and core in addition to crown	$0
	D2955		Post removal (not in conjunction with endodontic therapy)	$0
	D2957		Each additional prefabricated post - same tooth	$0
	D2962		Labial veneer - porcelain laminate (laboratory)	$0
			Rebond Veneer	$0
	D2971		Additional procedures to construct new crown under existing partial denture framework	$0
	D2980		Crown repair, by report	$0

ADA Code			*ADA Description	8000C3
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0
	D3221		Pulpal debridement, primary and permanent teeth	$0
ENDODONTIC THERAPY ON PRIMARY TEETH				
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$0
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$0
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$0
	D3331		Treatment of root canal obstruction; non-surgical access	$0
	D3332		Incomplete endodontic theraph;inoperable, unrestorable or fracture tooth	$0
	D3333		Internal root repair of perforation defects	$0
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$0
	D3347		Retreatment of previous root canal therapy - premolar	$0
	D3348		Retreatment of previous root canal therapy - molar	$0
APEXIFICATION / RECALCIFICATION				
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$0
	D3421		Apicoectomy premolar (first root)	$0
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0
	D3426		Apicoectomy (each additional root)	$0
	D3428		Bone graft in conjunction with periradicular surgery - per tooth, single site	$0
	D3429		Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$0
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$0
	D3472		Surgical repair of root resorption-premolar	$0
	D3473		Surgical repair of root resorption-molar	$0
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0

ADA Code			*ADA Description	8000C3
OTHER ENDODONTIC PROCEDURES				
	D3910		Surgical procedure for isolation of tooth with rubber dam	$0
	D3920		Hemisection (including any root removal), not including root canal therapy	$0
	D3950		Canal preparation and fitting of preformed dowel or post	$0
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4245		Apically positioned flap	$0
	D4249		Clinical crown lengthening - hard tissue	$0
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4263		Bone replacement graft - first site in quadrant	$0
	D4264		Bone replacement graft - each additional site in quadrant	$0
	D4274		Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
	D4355		Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$0
	D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth (up to 2 teeth per quad)	$0
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal maintenance	$0
	D4921		Gingival irrigation with a medicinal agent - per quadrant	$0
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$0
	D5120		Complete denture - mandibular	$0
	D5130		Immediate denture - maxillary	$0
	D5140		Immediate denture - mandibular	$0
PARTIAL DENTURES (including routine post-delivery care)				

	ADA Code		*ADA Description	8000C3
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$0
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$0
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$0
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$0
	D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$0
	D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$0
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$0
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$0
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$0
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$0
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$0
	D5411		Adjust complete denture - mandibular	$0
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair or replace broken clasp- per tooth	$0

	ADA Code		*ADA Description	8000C3
	D5640		Replace broken teeth - per tooth	$0
	D5650		Add tooth to existing partial denture	$0
	D5660		Add clasp to existing partial denture - per tooth	$0
	D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	$0
	D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	$0
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$0
	D5711		Rebase complete mandibular denture	$0
	D5720		Rebase maxillary partial denture	$0
	D5721		Rebase mandibular partial denture	$0
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline complete maxillary denture (laboratory)	$0
	D5751		Reline complete mandibular denture (laboratory)	$0
	D5760		Reline maxillary partial denture (laboratory)	$0
	D5761		Reline mandibular partial denture (laboratory)	$0
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5810		Interim complete denture (maxillary)	$0
	D5811		Interim complete denture (mandibular)	$0
	D5820		Interim partial denture (maxillary)	$0
	D5821		Interim partial denture (mandibular)	$0
	D5850		Tissue conditioning, maxillary	$0
	D5851		Tissue conditioning, mandibular	$0
IMPLANT SERVICES				
	D6010		Surgical placement of implant body: endosteal implant	$1,400
	D6058		Abutment supported porcelain/ceramic crown	$960
	D6059		Abutment supported porcelain fused to metal crown (high noble metal)	$965
	D6060		Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
	D6061		Abutment supported porcelain fused to metal crown (noble metal)	$930
	D6062		Abutment supported cast metal crown (high noble metal)	$925
	D6063		Abutment supported cast metal crown (predominantly base metal)	$800
	D6064		Abutment supported cast metal crown (noble metal)	$840
	D6065		Implant supported porcelain/ceramic crown	$955
	D6066		Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935

	ADA Code		*ADA Description	8000C3
	D6067		Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
	D6068		Abutment supported retainer for porcelain/ceramic FPD	$975
	D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
	D6070		Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915
	D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
	D6072		Abutment supported retainer for cast metal FPD (high noble metal)	$950
	D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
	D6074		Abutment supported retainer for cast metal FPD (noble metal)	$925
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0
	D6094		Abutment supported crown - (titanium)	$600
	D6191		Semi-precision abutment - placement	$600
	D6192		Semi-precision attachment - placement	$600
	D6194		Abutment supported retainer crown for FPD (titanium)	$500
	D6195		Abutment supported retainer - porcelain fused to titanium or titanium alloy	$0
FIXED PARTIAL DENTURE PONTICS				
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$0
	D6210		Pontic - cast high noble metal	$0
	D6211		Pontic - cast predominantly base metal	$0
	D6212		Pontic - cast noble metal	$0
	D6214		Pontic - titanium	$0
	D6240		Pontic - porcelain fused to high noble metal	$0
	D6241		Pontic - porcelain fused to predominantly base metal	$0
	D6242		Pontic - porcelain fused to noble metal	$0
	D6243		Pontic - porcelain fused to titanium or titanium alloys	$0
	D6245		Pontic - porcelain/ceramic	$0
	D6250		Pontic - resin with high noble metal	$0
	D6251		Pontic - resin with predominantly base metal	$0
	D6252		Pontic - resin with noble metal	$0
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$0
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6710		Crown - indirect resin based composite	$0
	D6720		Crown - resin with high noble metal	$0
	D6721		Crown - resin with predominantly base metal	$0

	ADA Code		*ADA Description	8000C3
	D6722		Crown - resin with noble metal	$0
	D6740		Crown - porcelain/ceramic	$0
	D6750		Crown - porcelain fused to high noble metal	$0
	D6751		Crown - porcelain fused to predominantly base metal	$0
	D6752		Crown - porcelain fused to noble metal	$0
	D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$0
	D6780		Crown - 3/4 cast high noble metal	$0
	D6781		Crown - 3/4 cast predominantly base metal	$0
	D6782		Crown - 3/4 cast noble metal	$0
	D6783		Crown - 3/4 cast porcelain/ceramic	$0
	D6784		Retainer crown 3/4 - titaninium and titanium alloys	$0
	D6790		Crown - full cast high noble metal	$0
	D6791		Crown - full cast predominantly base metal	$0
	D6792		Crown - full cast noble metal	$0
	D6794		Crown - titanium	$0
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
	D6940		Stress breaker	$0
	D6980		Fixed partial denture repair, by report	$0
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$0
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0
	D7220		Removal of impacted tooth - soft tissue	$0
	D7230		Removal of impacted tooth - partially bony	$0
	D7240		Removal of impacted tooth - completely bony	$0
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$0
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0
OTHER SURGICAL PROCEDURES				
	D7270		Tooth reimplantation and/or stabilization of accidentally evulsed o	$0
	D7280		Surgical access of an unerupted tooth	$0
	D7283		Placement of device to facilitate eruption of impacted tooth	$0
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
	D7288		Brush biopsy - transepithelial sample collection	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0

	ADA Code		*ADA Description	8000C3
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0
EXCISION OF BONE TISS		**U**		
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
	D7485		Surgical reduction of osseous tuberosity	$0
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0
	D7520		Incision and drainage of abscess - extraoral soft tissue	$0
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0
	D7953		Bone replacement graft for ridge preservation - per site	$0
	D7961		buccal/labial frenectomy	$0
	D7962		lingual frenectomy	$0
	D7963		Frenuloplasty	$0
	D7970		Excision of hyperplastic tissue - per arch	$0
	D7971		Excision of pericoronal gingiva	$0
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8010		Limited orthodontic treatment of the primary dentition	$800
	D8020		Limited orthodontic treatment of the transitional dentition	$800
	D8030		Limited orthodontic treatment of the adolescent dentition	$800
	D8040		Limited orthodontic treatment of the adult dentition	$800
	D8050		Interceptive orthodontic treatment of the primary dentition	$950
	D8060		Interceptive orthodontic treatment of the transitional dentition	$950
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,600
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,600
	D8090		Comprehensive orthodontic treatment of the adult dentition	$2,100
OTHER ORTHODONTIC SERVICES				
			Orthodontic material upgrade - gold or clear brackets	$210
			Invisalign or any similar product	$350
	D8660		Pre-orthodontic treatment visit	$0
	D8670		Periodic orthodontic treament visit	$50
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
	D8681		Removable orthodontic retainer adjustment	$50
	D8999		Orthodontic records fee	$275

Schedule of Benefits

ADA Code	*ADA Description	8000C3
UNCLASSIFIED TREATMENT		
D9110	Palliative treatment of dental pain - per visit	$0
ANESTHESIA		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9222	Deep sedation/general anesthesia - first 15 minutes	$0
D9223	Deep sedation/general anesthesia - each 15 minute increment	$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$0
D9239	Intravenous conscious sedation/analgesia - first 15 minutes	$0
D9243	Intravenous conscious sedation/analgesia - 15 minute increment	$0
PROFESSIONAL CONSULTATION		
D9310	Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
PROFESSIONAL VISITS		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit, after regularly scheduled hours	$0
MISCELLANEOUS SERVICES		
D9910	Application of desensitizing medicament	$0
D9932	Cleaning and inspection of removable complete denture, maxillar	$0
D9933	Cleaning and inspection of removable complete denture, mandibu	$0
D9934	Cleaning and inspection of removable partial denture maxillary	$0
D9935	Cleaning and inspection of removable partial denture, mandibular	$0
D9944	Occlusal guard - hard appliance, full arch	$0
D9945	Occlusal guard - soft appliance, full arch	$0
D9946	Occlusal guard - hard appliance, partial arch	$0
D9951	Occlusal adjustment - limited	$0
D9952	Occlusal adjustment - complete	$0
D9972	External bleaching - per arch - take home trays	$0
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$0
NON CLINICAL PROCEDURES		
D9986	Missed appointment	$0
D9987	Cancelled appointment	$0
D9990	Certified Translation or Sign Language Services - per visit	$0
D9997	Dental case management - patients with special health care needs	$0

CDT 2024

LIMITATIONS & EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits:

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial
Images- once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered subject to the determination of the treating provider are:

1) Pregnancy,
2) Pre-radiation therapy as ordered by an oncologist,
3) Gingival hyperplasia due to the use of Dilantin or other medications,
4) Inflammation due to syphilis or tuberculosis,
5) Chronic menopausal gingivostomatitis,
6) Leukemia or HIV induced gingivitis.

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to two (2) treatments in a 12 consecutive month period.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Use of precious metal in fabrication of a crown, inlay or onlay is considered elective and an additional metal charge will apply.

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one (1) per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one (1) per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve (12) months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable.

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the arch in accordance with professionally recognized standards of dental practice.

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture.

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit.

The Plan provides coverage for up to six units for crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

LIMITATIONS & EXCLUSIONS

ORTHODONTIC COVERAGES

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

LIMITATIONS & EXCLUSIONS

EXCLUSIONS

The following dental procedures and services are excluded from this coverage by the Benefit Plan:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services

Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect.

Crowns and pontics supported on a dental implant.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Implant supported dentures, unless specifically listed as a covered benefit under your plan.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Implant supported bridges, unless specifically listed as a covered benefit under your plan.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided.
Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

Appliances to correct and control harmful habits (e.g. tongue thrust and thumb sucking).

LOS ANGELES UNIFIED SCHOOL DISTRICT

Schedule of Benefits

ADA CODE			*ADA DESCRIPTIONS	LAUSD
CLINICAL ORAL EVALUATIONS				
	D0120		Periodic Oral Eval - Established Patient	$0
	D0140		Limited Oral Eval - Problem Focused	$0
	D0145		Oral Evaluation For A Patient Under Three Years Of Age And Counselling With Primary Caregiver	$0
	D0150		Comprehensive Oral Eval - New Or Estab Patient	$0
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
	D0171		Re-Evaluation - Post-Operative Office Visit	$0
	D0180		Comprehensive periodontal evaluation - new or established patient	$0
	D0190		Screening of a patient	$0
	D0191		Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)				
	D0210		Intraoral - Complete Series	$0
	D0220		Intraoral-Periapical First Film	$0
	D0230		Intraoral-Periapical Each Additional Film	$0
	D0240		Intraoral - Occlusal Film	$0
	D0250		Extra-oral single film	$0
	D0270		Bitewing-1 Film	$0
	D0272		Bitewings-2 Films	$0
	D0273		Bitewings-3 Films	$0
	D0274		Bitewings-4 Films	$0
	D0277		Vertical bitewings - 7 to 8 films	$0
	D0330		Panoramic Film	$0
	D0340		Cephalometric Film	$0
	D0350		Oral/Facial Photographic Images	$0
TESTS AND EXAMINATIONS				
	D0419		Assement of salivary flow by measurement	$0
	D0460		Pulp Vitality Tests	$0
	D0470		Diagnostic Casts	$0
	D0601		Caries Risk Assessment - Low Risk	$0
	D0602		Caries Risk Assessment - Medium Risk	$0
	D0603		Caries Risk Assessment - High Risk	$0
	D0701		Panoramic radiographic image- image capture only	$0
	D0702		2-D cephalometric radiographic- image capture only	$0
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
	D0705		extra-oral posterior dental radiographic image capture only	$0
	D0706		intraoral- occlusal radiographic image- image capture only	$0
	D0707		intraoral- periapical radiographic image- image capture only	$0
	D0708		intraoral- bitewing radiographic image- image capture only	$0
	D0709		intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY				
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
	D0999		Unspecified Diagnostic Procedure, By Report	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - Adult	$0
	D1120		Prophylaxis - Child	$0
TOPICAL FLUORIDE TREATMENT (office procedure)				

Schedule of Benefits

ADA CODE			*ADA DESCRIPTIONS	LAUSD
	D1206		Top Fluoride Varnish; Tx Appl Mod-Hi Caries Risk	$0
	D1208		Topical Application Of Fluoride	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counselling	$0
	D1320		Tobacco counseling for the control and prevention of oral disease	$0
	D1330		Oral Hygiene Instructions	$0
	D1351		Sealant - Per Tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim Caries Arresting Medicament Application Per Tooth	$0
	D1355		Caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space Maintainer - Fixed - Unilateral	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0
	D1557		Removal of fixed bilateral space maintainer maxillary	$0
	D1558		Removal of fixed bilateral space maintainer mandibular	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - 1 Surface, Primary Or Permanent	$0
	D2150		Amalgam - 2 Surfaces, Primary Or Permanent	$0
	D2160		Amalgam - 3 Surfaces, Primary Or Permanent	$0
	D2161		Amalgam - 4 + Surfaces, Primary Or Permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-Based Composite - 1 Surface, Anterior	$0
	D2331		Resin-Based Composite - 2 Surfaces, Anterior	$0
	D2332		Resin-Based Composite - 3 Surfaces, Anterior	$0
	D2335		Resin-Based Composite - 4+ Surfaces, Anterior	$0
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-Based Composite - 1 Surface, Posterior	$0
	D2392		Resin-Based Composite - 2 Surfaces, Posterior	$0
	D2393		Resin-Based Composite - 3 Surfaces, Posterior	$0
	D2394		Resin-Based Composite - 4 Or More Surfaces, Posterior	$0
INLAY/ONLAY RESTORATIONS				
	D2510		Inlay - metallic - one surface	$0
	D2520		Inlay - metallic - two surfaces	$0
	D2530		Inlay - metallic - three or more surfaces	$0
	D2542		Onlay - metallic - two surfaces	$0
	D2543		Onlays - metallic - three surfaces	$0
	D2544		Onlays - metallic - four or more surfaces	$0
	D2610		Inlay - porcelain/ceramic - 1 surface	$0
	D2620		Inlay - porcelain/ceramic - 2 surfaces	$0
	D2630		Inlay - porcelain/ceramic - 3 or more surfaces	$0
	D2642		Onlay, porcelain/ceramic - 2 surfaces	$0
	D2643		Onlay, porcelain/ceramic - 3 surfaces	$0

Schedule of Benefits

	ADA CODE		*ADA DESCRIPTIONS	LAUSD
	D2651		Inlay - resin-based composite - 2 surfaces	$0
	D2652		Inlay - resin-based composite - 3 or more surfaces	$0
	D2662		Onlay - resin-based composite - 2 surfaces	$0
	D2663		Onlay - resin-based composite - 3 surfaces	$0
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect)	$0
	D2712		Crown - 3/4 resin-based composite (indirect)	$0
	D2720		Crown - resin with high noble metal	$0
	D2721		Crown - resin with predominantly base metal	$0
	D2722		Crown - resin with noble metal	$0
	D2740		Crown - Porc/Ceramic Substrate	$0
	D2750		Crown - Porc Fused To High Noble Metal	$0
	D2751		Crown - Porc Fused To Predom Base Metal	$0
	D2752		Crown - Porcelain Fused To Noble Metal	$0
	D2753		Crown- porcelain fused to titanium or titanium alloy	$0
	D2780		Crown - 3/4 cast high noble metal	$0
	D2781		Crown - 3/4 cast predominantly base metal	$0
	D2782		Crown - 3/4 cast noble metal	$0
	D2783		Crown - 3/4 porcelain/ceramic	$0
	D2790		Crown - full cast high noble metal	$0
	D2791		Crown - Full Cast Predominantly Base Metal	$0
	D2792		Crown - full cast noble metal	$0
	D2794		Crown - titanium	$0
	D2799		Provisional crown - To be used at least 6 months during healing	$0
OTHER RESTORATIVE SERVICES				
	D2910		Recement Inlay Onlay/Part Coverage Restoration	$0
	D2915		Recement cast or prefabricated post and core	$0
	D2920		Recement Crown	$0
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2930		Prefab Stainless Steel Crn - Primary Tooth	$0
	D2931		Prefabr Stainless Steel Crown - Permanent Tooth	$0
	D2932		Prefabricated resin crown	$0
	D2933		Prefabricated stainless steel crown with resin window	$0
	D2934		Prefab Esthetic Coat Stnless Steel Crown Prim	$0
	D2940		Sedative filling	$0
	D2950		Core Buildup, Including Any Pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post And Core Addition To Crown Indirectly Fab	$0
	D2953		Each additional indirectly fabricated post - same tooth	$0
	D2954		Prefab Post & Core In Addition To Crown	$0
	D2955		Post Removal	$0
	D2957		Each additional prefabricated post - same tooth	$0
	D2962		Labial veneer - porcelain laminate (laboratory)	$0
	D2971		Additional procedures to construct new crown under existing partial denture framework	$0
	D2980		Crown Repair By Report	$0
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp Cap - Indirect	$0
PULPOTOMY				
	D3220		Therapeutic Pulpotomy (Excl Final Rest)	$0
	D3221		Pulpal Debridement, Primary/Permanent Teeth	$0
ENDODONTIC THERAPY ON PRIMARY TEETH				
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0

Schedule of Benefits

	ADA CODE		*ADA DESCRIPTIONS	LAUSD
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Endo Therapy, Anterior Tooth (Excl Final Rest)	$0
	D3320		Endo Therapy, Bicuspid Tooth (Excl Final Rest)	$0
	D3330		Endo Therapy, Molar (Excl Final Rest)	$0
	D3331		Treatment of root canal obstruction; non-surgical access	$0
	D3332		Incomplete endodontic theraph;inoperable, unrestorable or fracture tooth	$0
	D3333		Internal root repair of perforation defects	$0
ENDODONTIC RETREATMENT				
	D3346		Retreatment Of Prev Root Canal-Anterior	$0
	D3347		Retreatment Previous Rc Therapy - Bicuspid	$0
	D3348		Retreatment Of Prev Root Canal-Molar	$0
APEXIFICATION/RECALCIFICATION				
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$0
	D3421		Apicoectomy premolar (first root)	$0
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0
	D3426		Apicoectomy (each additional root)	$0
	D3428		Bone graft in conjunction with periradicular surgery - per tooth, single site	$0
	D3429		Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$0
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$0
	D3472		Surgical repair of root resorption-premolar	$0
	D3473		Surgical repair of root resorption-molar	$0
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0
OTHER ENDODONTIC PROCEDURES				
	D3910		Surgical procedure for isolation of tooth with rubber dam	$0
	D3920		Hemisection (including any root removal), not including root canal therapy	$0
	D3950		Canal preparation and fitting of preformed dowel or post	$0
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivect/Plsty 4/>Cntig/Tooth Bound Spaces-Quad	$0
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4245		Apically positioned flap	$0
	D4249		Clinical Crown Lengthening - Hard Tissue	$0
	D4260		Osseous Surgery Per Quad/4+ Contig Teeth	$0
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4263		Bone Graft/First Site In Quadrant	$0
	D4264		Bone Replacement Graft - Ea Add Site Quadrant	$0
	D4274		Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$0
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Perio Scaling/Planing - Per Quad, 4+ Contig Teeth	$0
	D4342		Perio Scaling/Planing - Per Quad, 1-3 Teeth/Quad	$0
	D4346		Scaling In Presence Of Gingival Inflammation	$0
	D4355		Full Mouth Debridement	$0
	D4381		Local Del Of Antimicrobial Agents, Per Tooth	$0
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal Maintenance	$0
	D4921		Gingival Irrigation - Per Quadrant	$0

Schedule of Benefits

ADA CODE			*ADA DESCRIPTIONS	LAUSD
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete Denture - Maxillary	$0
	D5120		Complete Denture - Mandibular	$0
	D5130		Immediate Denture - Maxillary	$0
	D5140		Immediate Denture - Mandibular	$0
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary Partial Dent - Resin Base	$0
	D5212		Mandibular Partial Dent - Resin Base	$0
	D5213		Maxillary Partial Dent - Cast Metal Framework	$0
	D5214		Mandibular Partial Dent - Cast Metal Framework	$0
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$0
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$0
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$0
	D5225		Maxillary Partial Dent - Flexible Base	$0
	D5226		Mandibular Partial Dent - Flexible Base	$0
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$0
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$0
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$0
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$0
ADJUSTMENTS TO DENTURES				
	D5410		Adjust Complete Denture - Maxillary	$0
	D5411		Adjust complete denture - mandibular	$0
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace Missing/Broken Teeth/Complete Dent	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair Or Replace Broken Clasp	$0
	D5640		Replace Broken Teeth - Per Tooth	$0
	D5642		Replace missing/broke tooth each additional	$0
	D5650		Add Tooth To Existing Partial Denture	$0
	D5660		Add Clasp To Existing Partial Denture	$0
	D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	$0
	D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	$0
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$0
	D5711		Rebase complete mandibular denture	$0
	D5720		Rebase maxillary partial denture	$0
	D5721		Rebase mandibular partial denture	$0
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline Complete Maxillary Denture Laboratory	$0
	D5751		Reline Complete Mandibular Denture (Lab)	$0
	D5760		Reline maxillary partial denture (laboratory)	$0
	D5761		Reline mandibular partial denture (laboratory)	$0
	D5862		Precision attachment, by report	$455
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5810		Interim complete denture (maxillary)	$0

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	ADA CODE		*ADA DESCRIPTIONS	LAUSD
	D5811		Interim complete denture (mandibular)	$0
	D5820		Interim partial denture (maxillary)	$0
	D5821		Interim partial denture (mandibular)	$0
	D5850		Tissue Conditioning Maxillary	$0
	D5851		Tissue Conditioning, Mandibular	$0
IMPLANT SERVICES				
	D6010	@	Surg Placement Implant Body: Endosteal Implant	$1,299
	D6053		Implant/abutment supported removable denture for completely edentulous arch	$1,200
	D6056		Prefabricated Abutment Includes Placement	$425
	D6057		Custom Abutment Includes Placement	$525
	D6058	@	Abut Supp Porcelain / Ceramic Crown	$790
	D6059	@	Abut Supp Porcelain To Metl Crown Hi Noble Metl	$799
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
	D6061		Abutment supported porcelain fused to metal crown (noble metal)	$930
	D6062	@	Abutment supported cast metal crown (high noble metal)	$925
	D6063		Abutment supported cast metal crown (predominantly base metal)	$800
	D6064		Abutment supported cast metal crown (noble metal)	$840
	D6065	@	Implant supported porcelain/ceramic crown	$955
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
	D6068		Abutment supported retainer for porcelain/ceramic FPD	$975
	D6069		Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
	D6070		Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915
	D6071		Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
	D6072		Abutment supported retainer for cast metal FPD (high noble metal)	$950
	D6073		Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
	D6074		Abutment supported retainer for cast metal FPD (noble metal)	$925
	D6100		Implant removal, by report	$499
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0
	D6094		Abutment supported crown - (titanium)	$600
	D6191		Semi-precision abutment - placement	$600
	D6192		Semi-precision attachment - placement	$600
	D6194		Abutment supported retainer crown for FPD (titanium)	$500
	D6195		Abutment supported retainer - porcelain fused to titanium or titanium alloy	$0
FIXED PARTIAL DENTURE PONTICS				
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$0
	D6210		Pontic - cast high noble metal	$0
	D6211		Pontic - cast predominantly base metal	$0
	D6212		Pontic - cast noble metal	$0
	D6214		Pontic - titanium	$0
	D6240		Pontic - Porcelain Fused To High Noble Metal	$0
	D6241		Pontic - Porcelain Fused To Predom Base Metal	$0
	D6242		Pontic - porcelain fused to noble metal	$0
	D6243		Pontic - porcelain fused to titanium or titanium alloys	$0
	D6245		Pontic- Porc/Ceramic	$0
	D6250		Pontic - resin with high noble metal	$0
	D6251		Pontic - resin with predominantly base metal	$0
	D6252		Pontic - resin with noble metal	$0
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$0
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6710		Crown - indirect resin based composite	$0
	D6720		Crown - resin with high noble metal	$0

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ADA CODE			*ADA DESCRIPTIONS	LAUSD
	D6721		Crown - resin with predominantly base metal	$0
	D6722		Crown - resin with noble metal	$0
	D6740		Crown - Porcelain/Ceramic	$0
	D6750		Crown - Porc Fused To High Noble Metal	$0
	D6751		Crown - Porc Fused To Predom Base Metal	$0
	D6752		Crown - porcelain fused to noble metal	$0
	D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$0
	D6780		Crown - 3/4 cast high noble metal	$0
	D6781		Crown - 3/4 cast predominantly base metal	$0
	D6782		Crown - 3/4 cast noble metal	$0
	D6783		Crown - 3/4 cast porcelain/ceramic	$0
	D6784		Retainer crown 3/4 - titaninium and titanium alloys	$0
	D6790		Crown - full cast high noble metal	$0
	D6791		Crown - full cast predominantly base metal	$0
	D6792		Crown - full cast noble metal	$0
	D6794		Crown - titanium	$0
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement Fixed Partial Denture	$0
	D6940		Stress breaker	$0
	D6971		Crown - full cast predominantly base metal	$0
	D6980		Fixed partial denture repair, by report	$0
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$0
	D7140		Extraction - Single Tooth	$0
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical Removal Of Erupted Tooth	$0
	D7220		Rmvl Of Impacted Tooth - Soft Tissue	$0
	D7230		Rmvl Of Impacted Tooth - Part Bony	$0
	D7240		Rmvl Of Impacted Tooth - Comp Bony	$0
	D7241		Rmvl Of Impacted Tooth - Comp Bony (W/Complic)	$0
	D7250		Surgical Removal Of Residual Tooth Roots	$0
OTHER SURGICAL PROCEDURES				
	D7270		Tooth reimplantation and/or stabilization of accidentally evulsed o	$0
	D7280		Surgical access of an unerupted tooth	$0
	D7283		Placement of device to facilitate eruption of impacted tooth	$0
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
	D7288		Brush biopsy - transepithelial sample collection	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty W/Extraction 4/> Teeth/Space Quad	$0
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0
EXCISION OF BONE TISSUE				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
	D7485		Surgical reduction of osseous tuberosity	$0
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0
	D7520		Incision and drainage of abscess - extraoral soft tissue	$0
OTHER REPAIR PROCEDURES				
	D7922		Placement Of Intra-Socket Dressing	$0
	D7953		Bone replacement graft for ridge preservation - per site	$0
	D7961		buccal/labial frenectomy	$0
	D7962		lingual frenectomy	$0
	D7963		Frenuloplasty	$0
	D7970		Excision of hyperplastic tissue - per arch	$0
	D7971		Excision of pericoronal gingiva	$0
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8010		Limited orthodontic treatment of the primary dentition	$800
	D8020		Limited orthodontic treatment of the transitional dentition	$800

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	ADA CODE		*ADA DESCRIPTIONS	LAUSD
	D8030		Limited orthodontic treatment of the adolescent dentition	$800
	D8040		Limited orthodontic treatment of the adult dentition	$800
	D8050		Interceptive orthodontic treatment of the primary dentition	$950
	D8060		Interceptive orthodontic treatment of the transitional dentition	$950
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,000
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,000
	D8090		Comprehensive orthodontic treatment of the adult dentition	$1,000
OTHER ORTHODONTIC SERVICES				
			Orthodontic material upgrade - gold or clear brackets	$210
			Invisalign or any similar product	$350
	D8660		Pre-orthodontic treatment visit	$0
	D8670		Periodic orthodontic treament visit	$50
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
	D8681		Removable orthodontic retainer adjustment	$50
	D8999		Orthodontic records fee	$275
UNCLASSIFIED TREATMENT				
	D9110		Emergency Treatment	$0
ANESTHESIA				
	D9210		Local anesthesia not in conjunction with operative or surgical procedures	$0
	D9211		Regional block anesthesia	$0
	D9212		Trigeminal division block anesthesia	$0
	D9215		Local anesthesia	$0
	D9222		Deep Sedation/General Anes - First 15 Mins	$0
	D9223		Deep Sedation/General Anesthesia - Each 15 Minute Increment	$0
	D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$0
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$0
	D9243		Intravenous Conscious Sedation/Anesthesia - Each Subsequent 15 Minute Increment	$0
PROFESSIONAL CONSULTATION				
	D9310		Consultation - Other Than Treating Doctor	$0
PROFESSIONAL VISITS				
	D9430		Office Visit Observation No Other Srvc Performed	$0
	D9440		Office visit, after regularly scheduled hours	$0
MISCELLANEOUS SERVICES				
	D9910		Application of desensitizing medicament	$0
	D9932		Cleaning and inspection of removable complete denture, maxillar	$0
	D9933		Cleaning and inspection of removable complete denture, mandibu	$0
	D9934		Cleaning and inspection of removable partial denture maxillary	$0
	D9935		Cleaning and inspection of removable partial denture, mandibular	$0
	D9944		Occlusal Guard, Hard Appliance, Full Arch	$0
	D9945		Occlusal Guard, Soft Appliance, Full Arch	$0
	D9946		Occlusal guard - hard appliance, partial arch	$0
	D9951		Occlusal Adjustment - Limited	$0
	D9952		Occlusal adjustment - complete	$0
	D9972		External Bleaching - Per Arch -Take Home	$0
	D9975		External bleaching for home application, per arch; includes materials and fabrication of custom trays	$0
NON CLINICAL PROCEDURES				
	D9986		Missed appointment	$0
	D9987		Cancelled appointment	$0
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9997		Dental case management - patients with special health care needs	$0

FOOTNOTES

@ Where available

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LAUSD Provider Minimum Guarantee

ADA CODE		* ADA DESCRIPTION	NOCAL Minimum Guarantee
CLINICAL ORAL EVALUATIONS			
D0120		Periodic oral examination - established patient	$9
D0140		Limited oral evaluation - problem focused	$11
D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$11
D0150		Comprehensive oral evaluation - new or established patient	$15
D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$11
D0180		Comprehensive periodontal evaluation - new or established patient	$15
CLINICAL XRAYS			
D0210			$10
D0330			$10
DENTAL PROPHYLAXIS			
D1110		Prophylaxis - adult	$22
		D1110 and D1120 additional prophy exceeding two in a 12 month period	$22
D1120		Prophylaxis - child	$18
		D1110 and D1120 additional prophy exceeding two in a 12 month period	$18
TOPICAL FLUORIDE TREATMENT (office procedure)			
D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$6
D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$5
OTHER PREVENTIVE SERVICES			
D1351		Sealant - per tooth	$10
AMALGAM RESTORATIONS (including polishing)			
D2140		Amalgam - one surface, primary or permanent	$16
D2150		Amalgam - two surfaces, primary or permanent	$21
D2160		Amalgam - three surfaces, primary or permanent	$24
D2161		Amalgam - four or more surfaces, primary or permanent	$29
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT			
D2330		Resin-based composite - one surface, anterior	$26
D2331		Resin-based composite - two surfaces, anterior	$28
D2332		Resin-based composite - three surfaces, anterior	$30
D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$38
D2390		Resin-based composite crown, anterior	$20
D2391		Resin-based composite - one surface, posterior	$85
D2392		Resin-based composite - two surfaces, posterior	$109
D2393		Resin-based composite - three surfaces, posterior	$133
D2394		Resin-based composite - four or more surfaces, posterior	$140
INLAY/ONLAY RESTORATIONS			
D2542		Onlay - metallic - two surfaces	$210
D2543		Onlays - metallic - three surfaces	$162
D2544		Onlays - metallic - four or more surfaces	$169
CROWNS - SINGLE RESTORATIONS ONLY			
D2710		Crown - resin-based composite (indirect)	$100

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D2712		Crown - 3/4 resin-based composite (indirect)	$100
D2720		Crown - resin with high noble metal	$225
D2721		Crown - resin with predominantly base metal	$160
D2722		Crown - resin with noble metal	$200
D2740		Crown - porcelain/ceramic	$300
D2750		Crown - porcelain fused to high noble metal	$350
D2751		Crown - porcelain fused to predominantly base metal	$300
D2752		Crown - porcelain fused to noble metal	$350
D2753		Crown- porcelain fused to titanium or titanium alloy	$210
D2780		Crown - 3/4 cast high noble metal	$173
D2781		Crown - 3/4 cast predominantly base metal	$335
D2782		Crown - 3/4 cast noble metal	$330
D2783		Crown - 3/4 porcelain/ceramic	$270
D2790		Crown - full cast high noble metal	$330
D2791		Crown - full cast predominantly base metal	$265
D2792		Crown - full cast noble metal	$330
D2794		Crown - titanium	$270
OTHER RESTORATIVE SERVICES			
D2930		Prefabricated stainless steel crown - primary tooth	$36
D2931		Prefabricated stainless steel crown - permanent tooth	$40
D2932		Prefabricated resin crown	$38
D2933		Prefabricated stainless steel crown with resin window	$52
D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$14
D2940		Sedative filling	$14
D2950		Core buildup, involving and including any pins	$10
D2951		Pin retention - per tooth, in addition to restoration	$10
D2952		Post and core in addition to crown, indirectly fabricated	$53
D2953		Each additional indirectly fabricated post - same tooth	$10
D2954		Prefabricated post and core in addition to crown	$42
PULP CAPPING			
D3110		Pulp cap - direct (excluding final restoration)	$20
D3120		Pulp cap - indirect (excluding final restoration)	$50
PULPOTOMY			
D3220		Therapeutic pulpotomy (excluding final restoration)	$22
D3221		Pulpal debridement, primary and permanent teeth	$10
ENDODONTIC THERAPY ON PRIMARY TEETH			
D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$18
D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$28
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)			
D3310		Anterior (excluding final restoration)	$100
D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$124
D3330		Endodontic therapy, molar tooth (excluding final restoration)	$260
D3331		Treatment of root canal obstruction; non-surgical access	$60
D3332		Incomplete endodontic theraph;inoperable, unrestorable or fracture tooth	$40
D3333		Internal root repair of perforation defects	$50
ENDODONTIC RETREATMENT			
D3346		Retreatment of previous root canal therapy - anterior	$135
D3347		Retreatment of previous root canal therapy - premolar	$161

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D3348		Retreatment of previous root canal therapy - molar	$300
NON-SURGICAL PERIODONTAL SERVICES			
D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$30
D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$16
D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$20
D4355		Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit	$27
D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	$14
OTHER PERIODONTAL SERVICES			
D4910		Periodontal maintenance	$24
D4921		Gingival Irrigation - Per Quadrant	$8
COMPLETE DENTURES (including routine post-delivery care)			
D5110		Complete denture - maxillary	$350
D5120		Complete denture - mandibular	$350
D5130		Immediate denture - maxillary	$380
D5140		Immediate denture - mandibular	$380
PARTIAL DENTURES (including routine post-delivery care)			
D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$250
D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$250
D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$375
D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$375
D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$300
D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$300
D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$300
D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$365
D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$365
ADJUSTMENTS TO DENTURES			
D5410		Adjust complete denture - maxillary	$5
D5411		Adjust complete denture - mandibular	$5
D5421		Adjust partial denture - maxillary	$5
D5422		Adjust partial denture - mandibular	$5
DENTURE REBASE PROCEDURES			
D5710		Rebase complete maxillary denture	$100
D5711		Rebase complete mandibular denture	$100
D5720		Rebase maxillary partial denture	$100

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D5721		Rebase mandibular partial denture	$100
DENTURE RELINE PROCEDURES			
D5730		Reline complete maxillary denture (chairside)	$65
D5731		Reline complete mandibular denture (chairside)	$65
D5740		Reline maxillary partial denture (chairside)	$65
D5741		Reline mandibular partial denture (chairside)	$65
D5750		Reline complete maxillary denture (laboratory)	$65
D5751		Reline complete mandibular denture (laboratory)	$65
D5760		Reline maxillary partial denture (laboratory)	$65
D5761		Reline mandibular partial denture (laboratory)	$65
FIXED PARTIAL DENTURE PONTICS			
D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$265
D6210		Pontic - cast high noble metal	$285
D6211		Pontic - cast predominantly base metal	$170
D6212		Pontic - cast noble metal	$285
D6214		Pontic - titanium	$200
D6240		Pontic - porcelain fused to high noble metal	$285
D6241		Pontic - porcelain fused to predominantly base metal	$225
D6242		Pontic - porcelain fused to noble metal	$285
D6243		Pontic - porcelain fused to titanium or titanium alloys	$300
D6245		Pontic - porcelain/ceramic	$300
D6250		Pontic - resin with high noble metal	$335
D6251		Pontic - resin with predominantly base metal	$265
D6252		Pontic - resin with noble metal	$335
FIXED PARTIAL DENTURE RETAINERS - CROWNS			
D6710		Crown - indirect resin based composite	$265
D6720		Crown - resin with high noble metal	$260
D6721		Crown - resin with predominantly base metal	$225
D6722		Crown - resin with noble metal	$265
D6740		Crown - porcelain/ceramic	$265
D6750		Crown - porcelain fused to high noble metal	$335
D6751		Crown - porcelain fused to predominantly base metal	$300
D6752		Crown - porcelain fused to noble metal	$335
D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$200
D6780		Crown - 3/4 cast high noble metal	$330
D6781		Crown - 3/4 cast predominantly base metal	$275
D6782		Crown - 3/4 cast noble metal	$335
D6783		Crown - 3/4 cast porcelain/ceramic	$265
D6784		Retainer crown 3/4 - titaninium and titanium alloys	$225
D6790		Crown - full cast high noble metal	$335
D6791		Crown - full cast predominantly base metal	$275
D6792		Crown - full cast noble metal	$335
D6794		Crown - titanium	$275
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7111		Extraction, coronal remnants - primary tooth	$10
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$36

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D7220		Removal of impacted tooth - soft tissue	$48
D7230		Removal of impacted tooth - partially bony	$64
D7240		Removal of impacted tooth - completely bony	$78
D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$82
D7250		Surgical removal of residual tooth roots (cutting procedure)	$38
ANESTHESIA			
D9222		Deep sedation/general anesthesia - first 15 minutes	$50
D9223		Deep sedation/general anesthesia - each 15 minute increment	$50
D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$10
D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$40
D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$40
COMPREHENSIVE ORTHODONTIC TREATMENT			
D8080		Comprehensive orthodontic treament of adolescent dentition	$1,500
D8090		Comprehensive orthodontic treatment of adult dentition	$1,500

Procedures listed above, and pre-authorized by Western Dental, are payable at 100% of the fee, less applicable patient copayment.

If the request for services is not authorized as a benefit under the Western Dental Plan, the member will be responsible for the full usual and customary fees for any such services rendered.

Radiographs are usually considered the responsibility of the general dentist through capitation. If the services are approved as part of the pre-authorization or referral they will be paid the fees listed above.

This amendment shall become effective upon the first of the month following the receipt and countersignature, or if the provider has not provided a written response of non-exceptance and shall remain in effect until terminated by either. The schedule will automatically terminate when the provider agreement is terminated. This amendment will terminate if a new amendment it entered into by both parties.

This amendment supersedes and cancels any previous amendment between the Dentist and Western Dental. All terms of the Western Dental Provider Agreement shall remain in effect. Payment will be subject to retrospective clinical review.

LAUSD Provider Minimum Guarantee

ADA CODE		* ADA DESCRIPTION	SOCAL Minimum Guarantee
CLINICAL ORAL EVALUATIONS			
D0120		Periodic oral examination - established patient	$9
D0140		Limited oral evaluation - problem focused	$11
D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$11
D0150		Comprehensive oral evaluation - new or established patient	$15
D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$11
D0180		Comprehensive periodontal evaluation - new or established patient	$15
DENTAL PROPHYLAXIS			
D1110		Prophylaxis - adult	$22
		D1110 and D1120 additional prophy exceeding two in a 12 month period	$22
D1120		Prophylaxis - child	$18
		D1110 and D1120 additional prophy exceeding two in a 12 month period	$18
TOPICAL FLUORIDE TREATMENT (office procedure)			
D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$6
D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$5
OTHER PREVENTIVE SERVICES			
D1351		Sealant - per tooth	$10
AMALGAM RESTORATIONS (including polishing)			
D2140		Amalgam - one surface, primary or permanent	$16
D2150		Amalgam - two surfaces, primary or permanent	$21
D2160		Amalgam - three surfaces, primary or permanent	$24
D2161		Amalgam - four or more surfaces, primary or permanent	$29
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT			
D2330		Resin-based composite - one surface, anterior	$26
D2331		Resin-based composite - two surfaces, anterior	$28
D2332		Resin-based composite - three surfaces, anterior	$30
D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$38
D2390		Resin-based composite crown, anterior	$20
D2391		Resin-based composite - one surface, posterior	$85
D2392		Resin-based composite - two surfaces, posterior	$109
D2393		Resin-based composite - three surfaces, posterior	$133
D2394		Resin-based composite - four or more surfaces, posterior	$140
INLAY/ONLAY RESTORATIONS			
D2542		Onlay - metallic - two surfaces	$210
D2543		Onlays - metallic - three surfaces	$162
D2544		Onlays - metallic - four or more surfaces	$169
CROWNS - SINGLE RESTORATIONS ONLY			
D2710		Crown - resin-based composite (indirect)	$75
D2712		Crown - 3/4 resin-based composite (indirect)	$75
D2720		Crown - resin with high noble metal	$225
D2721		Crown - resin with predominantly base metal	$160
D2722		Crown - resin with noble metal	$200

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D2740		Crown - porcelain/ceramic	$300
D2750		Crown - porcelain fused to high noble metal	$350
D2751		Crown - porcelain fused to predominantly base metal	$300
D2752		Crown - porcelain fused to noble metal	$350
D2753		Crown- porcelain fused to titanium or titanium alloy	$210
D2780		Crown - 3/4 cast high noble metal	$173
D2781		Crown - 3/4 cast predominantly base metal	$335
D2782		Crown - 3/4 cast noble metal	$168
D2783		Crown - 3/4 porcelain/ceramic	$178
D2790		Crown - full cast high noble metal	$250
D2791		Crown - full cast predominantly base metal	$200
D2792		Crown - full cast noble metal	$200
D2794		Crown - titanium	$200
OTHER RESTORATIVE SERVICES			
D2930		Prefabricated stainless steel crown - primary tooth	$36
D2931		Prefabricated stainless steel crown - permanent tooth	$40
D2932		Prefabricated resin crown	$38
D2933		Prefabricated stainless steel crown with resin window	$52
D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$14
D2940		Sedative filling	$14
D2950		Core buildup, involving and including any pins	$10
D2951		Pin retention - per tooth, in addition to restoration	$10
D2952		Post and core in addition to crown, indirectly fabricated	$53
D2953		Each additional indirectly fabricated post - same tooth	$10
D2954		Prefabricated post and core in addition to crown	$42
PULP CAPPING			
D3110		Pulp cap - direct (excluding final restoration)	$11
D3120		Pulp cap - indirect (excluding final restoration)	$14
PULPOTOMY			
D3220		Therapeutic pulpotomy (excluding final restoration)	$22
D3221		Pulpal debridement, primary and permanent teeth	$10
ENDODONTIC THERAPY ON PRIMARY TEETH			
D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$18
D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$28
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)			
D3310		Anterior (excluding final restoration)	$100
D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$124
D3330		Endodontic therapy, molar tooth (excluding final restoration)	$160
D3331		Treatment of root canal obstruction; non-surgical access	$60
D3332		Incomplete endodontic theraph;inoperable, unrestorable or fracture tooth	$40
D3333		Internal root repair of perforation defects	$50
ENDODONTIC RETREATMENT			
D3346		Retreatment of previous root canal therapy - anterior	$135
D3347		Retreatment of previous root canal therapy - premolar	$161
D3348		Retreatment of previous root canal therapy - molar	$194
NON-SURGICAL PERIODONTAL SERVICES			
D4263		Bone Graft/First Site in Quadrant	$120
D4264		Bone Replacement Graft - ea add site quad	$92

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D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$30
D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$16
D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$20
D4355		Full mouth debridement to enable comprehensive evaluation and diagnosis on a subsequent visit	$27
D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	$14
OTHER PERIODONTAL SERVICES			
D4910		Periodontal maintenance	$24
D4921		Gingival Irrigation - Per Quadrant	$8
COMPLETE DENTURES (including routine post-delivery care)			
D5110		Complete denture - maxillary	$325
D5120		Complete denture - mandibular	$325
D5130		Immediate denture - maxillary	$325
D5140		Immediate denture - mandibular	$325
PARTIAL DENTURES (including routine post-delivery care)			
D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$170
D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$170
D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$300
D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$300
D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$300
D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$300
D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$300
D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$300
D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$300
ADJUSTMENTS TO DENTURES			
D5410		Adjust complete denture - maxillary	$5
D5411		Adjust complete denture - mandibular	$5
D5421		Adjust partial denture - maxillary	$5
D5422		Adjust partial denture - mandibular	$5
DENTURE REBASE PROCEDURES			
D5710		Rebase complete maxillary denture	$100
D5711		Rebase complete mandibular denture	$100
D5720		Rebase maxillary partial denture	$100
D5721		Rebase mandibular partial denture	$100
DENTURE RELINE PROCEDURES			
D5730		Reline complete maxillary denture (chairside)	$65

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D5731		Reline complete mandibular denture (chairside)	$65
D5740		Reline maxillary partial denture (chairside)	$65
D5741		Reline mandibular partial denture (chairside)	$65
D5750		Reline complete maxillary denture (laboratory)	$65
D5751		Reline complete mandibular denture (laboratory)	$65
D5760		Reline maxillary partial denture (laboratory)	$65
D5761		Reline mandibular partial denture (laboratory)	$65
FIXED PARTIAL DENTURE PONTICS			
D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$150
D6210		Pontic - cast high noble metal	$175
D6211		Pontic - cast predominantly base metal	$170
D6212		Pontic - cast noble metal	$175
D6214		Pontic - titanium	$175
D6240		Pontic - porcelain fused to high noble metal	$164
D6241		Pontic - porcelain fused to predominantly base metal	$175
D6242		Pontic - porcelain fused to noble metal	$175
D6243		Pontic - porcelain fused to titanium or titanium alloys	$300
D6245		Pontic - porcelain/ceramic	$300
D6250		Pontic - resin with high noble metal	$300
D6251		Pontic - resin with predominantly base metal	$130
D6252		Pontic - resin with noble metal	$164
FIXED PARTIAL DENTURE RETAINERS - CROWNS			
D6710		Crown - indirect resin based composite	$200
D6720		Crown - resin with high noble metal	$260
D6721		Crown - resin with predominantly base metal	$225
D6722		Crown - resin with noble metal	$265
D6740		Crown - porcelain/ceramic	$225
D6750		Crown - porcelain fused to high noble metal	$300
D6751		Crown - porcelain fused to predominantly base metal	$300
D6752		Crown - porcelain fused to noble metal	$300
D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$200
D6780		Crown - 3/4 cast high noble metal	$225
D6781		Crown - 3/4 cast predominantly base metal	$225
D6782		Crown - 3/4 cast noble metal	$225
D6783		Crown - 3/4 cast porcelain/ceramic	$200
D6784		Retainer crown 3/4 - titaninium and titanium alloys	$225
D6790		Crown - full cast high noble metal	$200
D6791		Crown - full cast predominantly base metal	$200
D6792		Crown - full cast noble metal	$200
D6794		Crown - titanium	$200
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7111		Extraction, coronal remnants - primary tooth	$10
D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$36
D7220		Removal of impacted tooth - soft tissue	$48
D7230		Removal of impacted tooth - partially bony	$64
D7240		Removal of impacted tooth - completely bony	$78

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D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$82
D7250		Surgical removal of residual tooth roots (cutting procedure)	$38
ANESTHESIA			
D9222		Deep sedation/general anesthesia - first 15 minutes	$50
D9223		Deep sedation/general anesthesia - each 15 minute increment	$50
D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$10
D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$40
D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$40
COMPREHENSIVE ORTHODONTIC TREATMENT			
D8080		Comprehensive orthodontic treament of adolescent dentition	$1,500
D8090		Comprehensive orthodontic treatment of adult dentition	$1,500

Procedures listed above, and pre-authorized by Western Dental, are payable at 100% of the fee, less applicable patient copayment.

If the request for services is not authorized as a benefit under the Western Dental Plan, the member will be responsible for the full usual and customary fees for any such services rendered.

Radiographs are usually considered the responsibility of the general dentist through capitation. If the services are approved as part of the pre-authorization or referral they will be paid the fees listed above.

This amendment shall become effective upon the first of the month following the receipt and countersignature, or if the provider has not provided a written response of non-exceptance and shall remain in effect until terminated by either. The schedule will automatically terminate when the provider agreement is terminated. This amendment will terminate if a new amendment it entered into by both parties.

This amendment supersedes and cancels any previous amendment between the Dentist and Western Dental. All terms of the Western Dental Provider Agreement shall remain in effect. Payment will be subject to retrospective clinical review.

LIMITATIONS AND EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits:

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial Images- once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered subject to the determination of the treating provider are:

1. Pregnancy,
2. Pre-radiation therapy as ordered by an oncologist,
3. Gingival hyperplasia due to the use of Dilantin or other medications,
4. Inflammation due to syphilis or tuberculosis,
5. Chronic menopausal gingivostomatitis,
6. Leukemia or HIV induced gingivitis.

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to three (3) treatments in a 12 consecutive month period for members through age 18.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one (1) per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one (1) per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve (12) months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the arch in accordance with professionally recognized standards of dental practice

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit

The Plan provides coverage for up to six units for crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

EXCLUSIONS

The following dental procedures and services are excluded from this coverage by the Benefit Plan:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services

Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances, except as specifically allowed under the Implant Services section of the schedule of benefits.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided.

Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

Appliances to correct and control harmful habits (e.g. tongue thrust and thumb sucking).

ORTHODONTIC COVERAGES

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

SAN DIEGO UNIFIED SCHOOL DISTRICT

Schedule of Benefits

ADA CODE	* ADA DESCRIPTION	SDPLUS
CLINICAL ORAL EVALUATIONS		
D0120	Periodic oral examination - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
D0171	Re-evaluation - post operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)		
D0210	Intraoral comprehensive series of radiographic images	$0
D0220	Intraoral - periapical radiographic image	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal radiographic	$0
D0250	Extra-oral single film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
TESTS AND EXAMINATIONS		
D0415	Collection of microorganisms for culture and sensitivity	$0
D0419	Assement of salivary flow by measurement	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0701	Panoramic radiographic image- image capture only	$0
D0702	2-D cephalometric radiographic- image capture only	$0
D0703	2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
D0705	extra-oral posterior dental radiographic image capture only	$0
D0706	intraoral- occlusal radiographic image- image capture only	$0
D0707	intraoral- periapical radiographic image- image capture only	$0
D0708	intraoral- bitewing radiographic image- image capture only	$0
D0709	intraoral- complete series of radiographic images- image capture only	$0
Oral Pathology Laboratory		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
CLINICAL ORAL EVALUATIONS				
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - adult	$0
			D1110 and D1120 additional prophy exceeding two in a 12 month period	$35
	D1120		Prophylaxis - child	$0
			D1110 and D1120 additional prophy exceeding two in a 12 mont	$35
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
	D1355		caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0
	D1557		Removal of fixed bilateral space maintainer maxillary	$0
	D1558		Removal of fixed bilateral space maintainer mandibular	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-based composite - one surface, posterior	$75
	D2392		Resin-based composite - two surfaces, posterior	$90
	D2393		Resin-based composite - three surfaces, posterior	$105
	D2394		Resin-based composite - four or more surfaces, posterior	$125
INLAY/ONLAY RESTORATIONS				
	D2510		Inlay - metallic - one surface	$0
	D2520		Inlay - metallic - two surfaces	$0
	D2530		Inlay - metallic - three or more surfaces	$0
	D2542		Onlay - metallic - two surfaces	$0
	D2543		Onlays - metallic - three surfaces	$0
	D2544		Onlays - metallic - four or more surfaces	$0
	D2610		Inlay - porcelain/ceramic - 1 surface (a)	$0
	D2620		Inlay - porcelain/ceramic - 2 surfaces (a)	$0
	D2630		Inlay - porcelain/ceramic - 3 or more surfaces (a)	$0
	D2642		Onlay, porcelain/ceramic - 2 surfaces (a)	$0
	D2643		Onlay, porcelain/ceramic - 3 surfaces (a)	$0
	D2644		Onlay - porcelain/ceramic - three or more surfaces (a)	$0
	D2650		Inlay - resin-based composite - one surface (a)	$0
	D2651		Inlay - resin-based composite - 2 surfaces (a)	$0
	D2652		Inlay - resin-based composite - 3 or more surfaces (a)	$0
	D2662		Onlay - resin-based composite - 2 surfaces (a)	$0
	D2663		Onlay - resin-based composite - 3 surfaces (a)	$0
	D2664		Onlay - resin-based composite - three surfaces (a)	$0
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect) (a)	$0
	D2712		Crown - 3/4 resin-based composite (indirect) (a)	$0
	D2720		Crown - resin with high noble metal (a,b)	$0
	D2721		Crown - resin with predominantly base metal (a)	$0
	D2722		Crown - resin with noble metal (a,b)	$0
	D2740		Crown - porcelain/ceramic (a)	$0
	D2750		Crown - porcelain fused to high noble metal (a,b)	$0
	D2751		Crown - porcelain fused to predominantly base metal (a)	$0
	D2752		Crown - porcelain fused to noble metal (a,b)	$0
	D2753		Crown- porcelain fused to titanium or titanium alloy (a,b)	$0
	D2780		Crown - 3/4 cast high noble metal (b)	$0
	D2781		Crown - 3/4 cast predominantly base metal	$0
	D2782		Crown - 3/4 cast noble metal (b)	$0
	D2783		Crown - 3/4 porcelain/ceramic (b)	$0
	D2790		Crown - full cast high noble metal (b)	$0
	D2791		Crown - full cast predominantly base metal	$0
	D2792		Crown - full cast noble metal (b)	$0
OTHER RESTORATIVE SERVICES				
	D2910		Recement inlay, onlay, or partial coverage restoration	$0
	D2915		Recement cast or prefabricated post and core	$0
	D2920		Recement crown	$0
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2930		Prefabricated stainless steel crown - primary tooth	$0
	D2931		Prefabricated stainless steel crown - permanent tooth	$0
	D2932		Prefabricated resin crown	$0
	D2940		Sedative filling	$0
	D2950		Core buildup, involving and including any pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D2952		Post and core in addition to crown, indirectly fabricated	$0
	D2953		Each additional indirectly fabricated post - same tooth	$0
	D2954		Prefabricated post and core in addition to crown	$0
	D2957		Each additional prefabricated post - same tooth	$0
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0
	D3221		Pulpal debridement, primary and permanent teeth	$0
ENDODONTIC THERAPY ON PRIMARY TEETH				
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$0
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$0
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$0
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$0
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$0
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$0
	D3347		Retreatment of previous root canal therapy - premolar	$0
	D3348		Retreatment of previous root canal therapy - molar	$0
Apexification/ Recalcificat		ion		
	D3351		Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3352		Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3353		Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair or perforations, root resorption, etc.)	$0
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$0
	D3421		Apicoectomy premolar (first root)	$0
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0
	D3426		Apicoectomy (each additional root)	$0
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$0
	D3472		Surgical repair of root resorption-premolar	$0
	D3473		Surgical repair of root resorption-molar	$0
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0
OTHER ENDODONTIC PROCEDURES				
	D3920		Hemisection (including any root removal), not including root canal therapy	$0
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
NON-SURGICAL PERIODONTAL SERVICES				
	D4320		Provisional splinting - intracoronal	$0
	D4321		Provisional splinting - extracoronal	$0
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
	D4355		Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$0
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal maintenance	$99
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$0
	D5120		Complete denture - mandibular	$0
	D5130		Immediate denture - maxillary	$0
	D5140		Immediate denture - mandibular	$0
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$0
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$0
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$0
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$0
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$0
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$0
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$0
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$0
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$0
	D5411		Adjust complete denture - mandibular	$0
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0
	D5524		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps rests and teeth)	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair or replace broken clasp- per tooth	$0
	D5640		Replace broken teeth - per tooth	$0
	D5650		Add tooth to existing partial denture	$0
	D5660		Add clasp to existing partial denture - per tooth	$0
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$0
	D5711		Rebase complete mandibular denture	$0
	D5720		Rebase maxillary partial denture	$0
	D5721		Rebase mandibular partial denture	$0
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline complete maxillary denture (laboratory)	$0
	D5751		Reline complete mandibular denture (laboratory)	$0
	D5760		Reline maxillary partial denture (laboratory)	$0
	D5761		Reline mandibular partial denture (laboratory)	$0
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5820		Interim partial denture (maxillary)	$0
	D5821		Interim partial denture (mandibular)	$0
	D5850		Tissue conditioning, maxillary	$0
	D5851		Tissue conditioning, mandibular	$0
Maxillofacial Prosthetics				
	D6010	@	Surgical placement of implant body: endosteal implant	$1,690
	D6058	@	Abutment supported porcelain/ceramic crown	$960
	D6059	@	Abutment supported porcelain fused to metal crown (high noble metal)	$965
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
	D6061	@	Abutment supported porcelain fused to metal crown (noble metal)	$930
	D6062	@	Abutment supported cast metal crown (high noble metal)	$925
	D6063	@	Abutment supported cast metal crown (predominantly base metal)	$800

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D6064	@	Abutment supported cast metal crown (noble metal)	$840
	D6065	@	Implant supported porcelain/ceramic crown	$955
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
	D6068	@	Abutment supported retainer for porcelain/ceramic FPD	$975
	D6069	@	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
	D6070	@	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915
	D6071	@	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
	D6072	@	Abutment supported retainer for cast metal FPD (high noble metal)	$950
	D6073	@	Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
	D6074	@	Abutment supported retainer for cast metal FPD (noble metal)	$925
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0
	D6194	@	Abutment supported retainer crown for FPD (titanium)	$500
FIXED PARTIAL DENTURE PONTICS				
	D6210		Pontic - cast high noble metal (b)	$0
	D6211		Pontic - cast predominantly base metal	$0
	D6212		Pontic - cast noble metal (b)	$0
	D6240		Pontic - porcelain fused to high noble metal (a,b)	$0
	D6241		Pontic - porcelain fused to predominantly base metal (a)	$0
	D6242		Pontic - porcelain fused to noble metal (a,b)	$0
	D6243		Pontic - porcelain fused to titanium or titanium alloys	$0
	D6245		Pontic - porcelain/ceramic (a)	$0
	D6250		Pontic - resin with high noble metal (a,b)	$0
	D6251		Pontic - resin with predominantly base metal (a)	$0
	D6252		Pontic - resin with noble metal (a,b)	$0
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6600		Inlay - porcelain/ceramic, two surfaces (a)	$0
	D6601		Inlay - porcelain/ceramic, three or more surfaces (a)	$0
	D6602		Inlay - cast high noble metal, two surfaces (b)	$0
	D6603		Inlay - cast high noble metal, three or more surfaces (b)	$0
	D6604		Inlay - cast predominantly base metal, two surfaces	$0
	D6605		Inlay - cast predominantly base metal, three or more surfaces	$0
	D6606		Inlay - cast noble metal, two surfaces (b)	$0
	D6607		Inlay - cast noble metal, three or more surfaces (b)	$0
	D6608		Onlay - porcelain/ceramic, two surfaces (a)	$0
	D6609		Onlay - porcelain/ceramic, three or more surfaces (a)	$0
	D6610		Onlay - cast high noble metal, two surfaces (b)	$0
	D6611		Onlay - cast high noble metal, three or more surfaces (b)	$0
	D6612		Onlay - cast predominantly base metal, two surfaces	$0
	D6613		Onlay - cast predominantly base metal, three or more surfaces	$0
	D6614		Onlay - cast noble metal, two surfaces (b)	$0
	D6615		Onlay - cast noble metal, three or more surfaces (b)	$0
FIXED PARTIAL DENTURE RETAINERS - CROWNS				

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D6720		Crown - resin with high noble metal (a,b)	$0
	D6721		Crown - resin with predominantly base metal (a)	$0
	D6722		Crown - resin with noble metal (a,b)	$0
	D6740		Crown - porcelain/ceramic (a)	$0
	D6750		Crown - porcelain fused to high noble metal (a,b)	$0
	D6751		Crown - porcelain fused to predominantly base metal (a)	$0
	D6752		Crown - porcelain fused to noble metal (a,b)	$0
	D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$0
	D6780		Crown - 3/4 cast high noble metal (a)	$0
	D6781		Crown - 3/4 cast predominantly base metal (b)	$0
	D6782		Crown - 3/4 cast noble metal (b)	$0
	D6783		Crown - 3/4 cast porcelain/ceramic (a)	$0
	D6790		Crown - full cast high noble metal (b)	$0
	D6791		Crown - full cast predominantly base metal	$0
	D6792		Crown - full cast noble metal (b)	$0
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
	D6940		Stress breaker	$0
	D6980		Fixed partial denture repair, by report	$0
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$0
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0
	D7220		Removal of impacted tooth - soft tissue	$0
	D7230		Removal of impacted tooth - partially bony	$0
	D7240		Removal of impacted tooth - completely bony	$0
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$0
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0
OTHER SURGICAL PROCEDURES				
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7340		Vestibuloplasty - ridge extension (secondary epithelialization)	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
Excision of Bone Tissue				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
	D7472		Removal of torus palatinus	$0
	D7473		Removal of torus mandibularis	$0
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0

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ADA CODE			* ADA DESCRIPTION	SDPLUS
	D7511		Incision drainage abscess intraoral soft tissue complicated	$0
	D7520		Incision and drainage of abscess - extraoral soft tissue	$0
	D7521		Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$0
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0
	D7953		Bone graft	$455
	D7961		buccal/labial frenectomy	$0
	D7962		lingual frenectomy	$0
	D7970		Excision of hyperplastic tissue - per arch	$0
	D7971		Excision of pericoronal gingiva	$0
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8010		Limited orthodontic treatment of the primary dentition	$500
	D8020		Limited orthodontic treatment of the transitional dentition	$500
	D8030		Limited orthodontic treatment of the adolescent dentition	$500
	D8040		Limited orthodontic treatment of the adult dentition	$500
	D8050		Interceptive orthodontic treatment of the primary dentition	$500
	D8060		Interceptive orthodontic treatment of the transitional dentition	$500
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,000
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,000
	D8090		Comprehensive orthodontic treatment of the adult dentition	$1,000
OTHER ORTHODONTIC SERVICES				
	D8660		Pre-orthodontic treatment visit	$25
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
	D8999		Orthodontic records fee	$0
UNCLASSIFIED TREATMENT				
	D9110		Palliative treatment of dental pain - per visit	$0
ANESTHESIA				
	D9211		Regional block anesthesia	$0
	D9212		Trigeminal division block anesthesia	$0
	D9215		Local anesthesia	$0
	D9222		Deep sedation/general anesthesia - first 15 minutes	$165
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$165
	D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$165
PROFESSIONAL CONSULTATION				
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
PROFESSIONAL VISITS				
	D9430		Office visit for observation (during regularly scheduled hours) - no other services performed	$0
	D9440		Office visit, after regularly scheduled hours	$0
	D9450		Case presentation, detailed and extensive treatment planning	$0
MISCELLANEOUS SERVICES				
	D9932		Cleaning and inspection of removable complete denture, maxilla	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	SDPLUS
	D9933		Cleaning and inspection of removable complete denture, mandib	$0
	D9934		Cleaning and inspection of removable partial denture maxillary	$0
	D9935		Cleaning and inspection of removable partial denture, mandibula	$0
	D9972		External bleaching - per arch - take home trays	$99
	D9975		External bleaching for home application, per arch; includes materials and fabrication of custom trays	$99
	NON CLINICAL PROCEDURES			
	D9986		Missed appointment	$10
	D9987		Cancelled appointment	$10
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9997		Dental case management - patients with special health care needs	$0

(a) Enrollee pays additional copayment of $150 for place on a molar tooth
(b) Enrollee pays additional copayment for lab cost of $100 for noble metal and $125 for high noble (precious) metal.

FOOTNOTES

@ Where available

CDT 2024

SD Plus Provider Supplemental Fees

ADA	Description	Supplemental Fee
D1510	Space Maintainer - Fixed Band type	$ 25.00
D1515	Space Maintainer - Fixed Bilateral	$ 25.00
D1520	Space Maintainer - Remv. Unilateral	$ 28.00
D1525	Space Maintainer - Remv. Bilateral	$ 28.00
D2161	Amalgam - four or more surfaces, primary or permanent	$ 15.00
D2740	Crown - porcelain/ceramic substrate	$ 85.00
D2750	Crown - porcelain fused to high noble metal	$ 120.00
D2751	Crown - porcelain fused to predominantly base metal	$ 120.00
D2752	Crown - porcelain fused to noble metal	$ 120.00
D2790	Crown - full cast high noble metal	$ 105.00
D2791	Crown - full cast predominantly base metal	$ 105.00
D2930	Prefabricated stainless steel crown - primary tooth	$ 30.00
D2931	Prefabricated stainless steel crown - permanent tooth	$ 30.00
D2950	Crown Build-up w/ pins	$ 8.00
D2952	Post and core in addition to crown indirectly fabricated	$ 8.00
D2954	Prefabricated post and core in addition to crown	$ 8.00
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$ 45.00
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$ 75.00
D3330	endodontic therapy, molar (excluding final restoration)	$ 100.00
D3410	Apicoectomy - Anterior	$ 60.00
D3421	Apicoectomy - Bicuspid (1st Root)	$ 60.00
D3425	Apicoectomy - Molar (1st Root)	$ 60.00
D3426	Apicoectomy - Each additional root	$ 60.00
D4210	Gingivectomy / Gingivoplasty - Four or more contiguous teeth per quad	$ 40.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$ 12.00
D5110	Complete denture - maxillary	$ 85.00
D5120	Complete denture - mandibular	$ 85.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$ 85.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$ 85.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 100.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$ 100.00
D5730	Reline complete upper denture - chairside	$ 20.00
D5731	Reline complete lower denture - chairside	$ 20.00
D5740	Reline partial upper denture - chairside	$ 20.00
D5741	Reline partial lower denture - chairside	$ 20.00
D5750	Reline complete maxillary denture (laboratory)	$ 35.00

SD Plus Provider Supplemental Fees

D5751	Reline complete mandibular denture (laboratory)	$	35.00
D5760	Reline maxillary partial denture (laboratory)	$	35.00
D5761	Reline mandibular partial denture (laboratory)	$	35.00
D6210	Pontic - cast high noble metal	$	65.00
D6212	Pontic - cast noble metal	$	65.00
D6240	Pontic - Porcelain fused to high noble metal	$	80.00
D6241	Pontic - Porcelain fused to predominantly base metal	$	80.00
D7210	Extraction erupted tooth req removal of bone and/ or sectioning of tooth incl. elevt.	$	15.00
D7220	Removal of impacted tooth - soft tissue	$	35.00
D7230	Removal of impacted tooth - partially bony	$	50.00
D7240	Removal of impacted tooth - completely bony	$	50.00

These items are not covered except where insufficient coronal structure remains to retain the crown restoration.

Periodontics
Subgingival Scaling and Root Planing:
This procedure is covered once every 12 months, unless necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

Prosthodontics, Removable
Complete and Partial Dentures:
Replacement of an existing appliance will be covered if the appliance is over 5 years old. Replacement of appliances that are less than 5 years old is covered only if the appliance was originally provided while the Member was not covered under any Western Dental Benefit Plan, if replacement is required as a result of clinically defective dentistry, or when replacement is necessary for the dental health of the Member consistent with professionally recognized standards of dental practice and preauthorized by Western Dental.

Tooth Additions and Repair to Existing Denture:
Repair of appliances damaged due to Member abuse is not covered.

Denture Reline and Rebase:
Relines of full or partial dentures are limited to 1 per calendar years, unless the Participating Provider determines that additional relines are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

Prosthodontics, Fixed
Fixed Partial Dentures, Pontics and Crowns:

1. Replacement of an existing appliance will be covered if the appliance is over 5 years old. The 5 year limitation does not apply to services rendered while the Member was not covered, or to replacement required as a result of clinically defective dentistry.
2. Precious metal Fixed Partial Dentures require an additional copayment for the noble metal or the high noble metal. (See Schedule of Benefits for detailed information).
3. Stress Breaker (non-rigid connector between the abutment and the Pontic) is not covered unless specifically listed as a Covered Service of your Benefit Plan in the Schedule of Benefits or the Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice

Fixed Partial Denture Services:
Posts are not covered except where insufficient coronal structure remains to retain the crown restoration.

Oral Surgery
Extractions for orthodontic purposes are *limited* to removal at a Western Dental Center office when the treatment can be performed at a Western Dental Center office, at the discretion of the Western Dental Center dentist.

LIMITATIONS
The following Limitations apply to Covered Services:

Diagnostic
Full Mouth X-Ray/Bitewing X-Ray:

1. Coverage for full mouth x-ray is limited to once in a two year period.
2. Coverage for bitewing x-rays is limited to no more than 1 series of 4 in any 6 month period, unless the Participating Provider determines additional x-rays are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

Preventive
Prophylaxis:
A prophylaxis is covered once in a 6 month period. An additional cleaning will be covered if the Participating Provider deems it necessary for the dental health of the Member, consistent with professionally recognized standards of dental practice. Examples of situations where an additional prophylaxis within the 6 month period may be necessary for the dental health of the Member and may be covered are:

1. Pregnancy;
2. Pre-radiation therapy as ordered by an oncologist;
3. Gingival hyperplasia due to the use of Dilantin or other medications;
4. Inflammation due to syphilis or tuberculosis;
5. Chronic menopausal gingivostomatitis; and
6. Leukemia or HIV induced gingivitis.

Fluoride Treatments:

1. Topical Fluoride is not a benefit for Members over the age of 19 years, unless the Participating Provider determines additional x-rays are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.
2. Topical Fluoride Treatments are limited to 1 treatment in a 12 consecutive month period, unless the Participating Provider determines additional x-rays are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

Restorative
Crowns:

1. Crowns will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that they do not hold a filling).
2. Replacement of an existing crown will be covered if the crown is over five years old or if the existing crown cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental practice. The five year limitation does not apply to clinically defective dentistry or to services rendered while the Member was not covered under this Benefit Plan.
3. Precious metal crowns – use of precious metal in fabrication of a crown requires an additional copayment for the noble metal or high noble metal. (See Schedule of Benefits for detailed information).

Other Restorative Services
Dowel Posts or Pins:

Orthodontics

The following services are not included in the Limited Orthodontic Treatment, Interceptive Orthodontic Treatment, or Comprehensive Orthodontic Treatment Copayments, and they are not Covered Services unless specifically listed in the Schedule of Benefits:

1. Start-up Services – Including preparation of orthodontic records consisting of x-rays, cephalometric x-rays, tracings, and case study models. The Member's Schedule of Benefits identifies a Start-up Services Copayment and the Member must pay the Copayment for Start-up Services. (See Schedule of Benefits for detailed information).
2. Retention – Retainers to hold and monitor the teeth following orthodontics (braces). The Member's Schedule of Benefits identifies a Retention Fee Copayment and the Member must pay the Copayment for Start-up Services. (See Schedule of Benefits for detailed information).
3. Services required because of Gross Non-Cooperation – Additional services required because Member's cooperation does not meet the minimum level necessary to complete the treatment adequately, or is damaging to the teeth.

   Should treatment extend beyond the original estimated treatment time due to Member's non-compliance, Member will be subject to an office visit Copayment for each additional office visit necessary until orthodontic are is completed. Each such office visit Copayment will equal the result obtained by dividing Member's total original treatment cost dividing by the number of month in the original treatment plan.
4. Post-treatment Records – X-rays, photographs and models following orthodontic treatment. The Member's Schedule of Benefits identifies a Post-Treatment Fee Copayment and the Member must pay the Copayment for the Post-Treatment Services. (See Schedule of Benefits for detailed information).

Specialist Referrals

Prior authorization from Western Dental is required for coverage of dental services provided by a Specialist. Referral to a participating Pediatric Dental Specialist for children under the age of 6 years is available and must be pre-authorized by Western Dental.

EXCLUSIONS
The following dental procedures and services are not covered by Western Dental. No dental service is covered unless specifically identified in the Schedule of Benefits.

Preventive
Supplies used for oral hygiene, plaque control, oral psychotherapy instruction, and chemical analysis of saliva.

Restorative
1. Crowns that are cosmetic in nature.
2. Crowns that are lost, stolen, or damaged when due to Member abuse, misuse, or neglect.
3. Porcelain, composite or acrylic crown restorations posterior to the second bicuspid, are considered purely cosmetic dentistry and require an additional copayment.

Periodontics
1. Crown lengthening – Surgical procedure involving the removal of gingiva and supporting bone to expose more tooth structure in the preparation for a crown procedure.
2. Soft Tissue Graft – Use of gingiva as a graft to repair a gingival defect or an exposed root.

Prosthodontics, Removable
1. Lost, stolen, or damaged appliances due to Member abuse.
2. Removable Prosthetic Services and supplies that are cosmetic in nature.
3. Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Prosthodontics, Fixed (Fixed Partial Dentures or Bridges)
1. Lost, stolen, or damaged Fixed Partial Dentures due to member abuse.
2. Distal extension posterior cantilever pontics, which are supported at the front end only.
3. Correction of occlusion or "occlusal equilibration" when performed independently of a completed restoration or a prosthesis may be recommended to treat Temporomandibular Joint Disorders (TMJ) or Myofacial pain. In such instances, correction of occlusion is not covered, since this Benefit Plan does not cover treatments of disturbances of the TMJ.
4. Facings on pontics and crowns posterior to the second bicuspid are considered to be cosmetic and require an additional Copayment.
5. Fixed Partial Dentures are not covered if the Member is missing teeth on opposite sides of the same arch, because a Removable Partial Denture is considered an adequate replacement. If the Member elects to receive a Fixed Partial Denture, the Member must pay the Participating Provider's charges that exceed the Copayment for a Removable Partial Denture as set forth in the Schedule of Benefits. This exclusion does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.
6. Fixed Partial Dentures are not covered unless a Removable Partial Denture cannot satisfactorily restore the case according to professionally recognized standards of dental practice. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.
7. Fixed Partial Dentures are not covered when abutment teeth are healthy and would be crowned only for the purpose of supporting a Pontic. If Fixed Partial Dentures are used under these circumstances, it is considered elective and is not a Covered Service, and the Member must pay

the Participating Provider's charges that exceed the Copayment for a Removable Partial denture as specified in the Schedule of Benefits. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Oral Surgery
Tuberosity Reduction – the process of reshaping of the bone supporting a dental prosthesis.

Orthodontics

1. TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.
2. Surgical Orthodontics – Surgical Orthodontics to reposition the jaw.
3. Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.
4. Orthognathic Surgery – Surgery to move the jaw bones into alignment.
5. Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.
6. Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.
7. Class III Orthodontics – Treatment for problems with the growth relationship of the upper and l9ower jaw resulting in positioning of the lower jaw or teeth in front of the upper jaw or teeth.
8. Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.
9. Retreatment of Orthodontic cases – The treatment of orthodontic problems that have been treated before.
10. Lost, Stolen, Damaged, or Broken Appliances – Damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist.
11. Extractions for Orthodontic Purposes – Are covered only when they can be performed at a Western Dental Center Office, at the discretion of the Western Dental Center Office dentist.

GENERAL EXCLUSIONS
The following general exclusions are applicable to all services:

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency treatment or upon prior authorization by Western Dental.
2. Charges for medical treatment, prescriptions, or other non-dental charges incurred.
3. Hospitalization costs for any dental procedure, included all hospital services and medications, will be borne by the Member. When deemed medically necessary by the Member's physician and preauthorized by Western Dental, otherwise covered dental services that are delivered in an inpatient or outpatient hospital setting are Covered Services under the Benefit Plan. All other associated expenses, including any applicable copayment for general anesthesia and IV conscious sedation, remain the responsibility of the Member.
4. Treatment of malignancies, neoplasms, and cysts.
5. Treatment of disturbances of the Temporomandibular Joint (TMJ).
6. Procedures, restorations, and appliances to correct congenital or developmental malformations.

7. Services and supplies which are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.
8. Dental expenses incurred in connection with any dental procedure started after termination of coverage.
9. Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage.
10. Appliances to correct and control harmful habits are not covered (e.g., tongue thrust and thumb sucking), unless specified in the Schedule of Benefits. This exclusion is not intended to eliminate coverage for dental services based on the cause of the underlying condition being treated.

CCPOA

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	CCPOA
CLINICAL ORAL EVALUATIONS				
	D0120		Periodic oral examination - established patient	$0
	D0140		Limited oral evaluation - problem focused	$0
	D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
	D0150		Comprehensive oral evaluation - new or established patient	$0
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
	D0171		Re-evaluation - post operative office visit	$0
	D0180		Comprehensive periodontal evaluation - new or established patient	$0
	D0190		Screening of a patient	$0
	D0191		Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)				
	D0210		Intraoral comprehensive series of radiographic images	$0
	D0220		Intraoral - periapical radiographic image	$0
	D0230		Intraoral - periapical each additional film	$0
	D0240		Intraoral - occlusal radiographic	$0
	D0250		Extra-oral single film	$0
	D0260		Extraoral - each additional film	$0
	D0270		Bitewing - single film	$0
	D0272		Bitewings - two films	$0
	D0273		Bitewings - three films	$0
	D0274		Bitewings - four films	$0
	D0277		Vertical bitewings - 7 to 8 films	$0
	D0330		Panoramic film	$0
	D0350		Oral/Facial Images	$0
TESTS AND EXAMINATIONS				
	D0419		Assement of salivary flow by measurement	$0
	D0460		Pulp vitality tests	$0
	D0601		Caries risk assessment and documentation, with a finding of low risk	$0
	D0602		Caries risk assessment and documentation, with a finding of moderate risk	$0
	D0603		Caries risk assessment and documentation, with a finding of high risk	$0
	D0701		Panoramic radiographic image- image capture only	$0
	D0702		2-D cephalometric radiographic- image capture only	$0
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra- orally - image capture only	$0
	D0705		extra-oral posterior dental radiographic image capture only	$0
	D0706		intraoral- occlusal radiographic image- image capture only	$0
	D0707		intraoral- periapical radiographic image- image capture only	$0
	D0708		intraoral- bitewing radiographic image- image capture only	$0
	D0709		intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY				
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - adult	$0
			D1110 and D1120 additional prophy exceeding two in a 12 month period	$0
	D1120		Prophylaxis - child	$0
			D1110 and D1120 additional prophy exceeding two in a 12 mont	$0
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0

Schedule of Benefits

	ADA CODE		* ADA DESCRIPTION	CCPOA
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1320		Tobacco counseling for the control and prevention of oral diseas	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
	D1355		caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-based composite - one surface, posterior	$25
	D2392		Resin-based composite - two surfaces, posterior	$35
	D2393		Resin-based composite - three surfaces, posterior	$45
	D2394		Resin-based composite - four or more surfaces, posterior	$55
INLAY/ONLAY RESTORATIONS				
	D2520	◆	Inlay - metallic - two surfaces	$60
	D2530	◆	Inlay - metallic - three or more surfaces	$60
	D2542	◆	Onlay - metallic - two surfaces	$50
	D2543	◆	Onlays - metallic - three surfaces	$50
	D2544	◆	Onlays - metallic - four or more surfaces	$50
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect)	$50
	D2712		Crown - 3/4 resin-based composite (indirect)	$50
	D2720	◆	Crown - resin with high noble metal	$50
	D2721		Crown - resin with predominantly base metal	$50
	D2722	◆	Crown - resin with noble metal	$50
	D2740		Crown - porcelain/ceramic	$50
	D2750	◆	Crown - porcelain fused to high noble metal	$50
	D2751		Crown - porcelain fused to predominantly base metal	$50
	D2752	◆	Crown - porcelain fused to noble metal	$50
	D2753	◆	Crown- porcelain fused to titanium or titanium alloy	$50
	D2780	◆	Crown - 3/4 cast high noble metal	$50
	D2781		Crown - 3/4 cast predominantly base metal	$50

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	ADA CODE		* ADA DESCRIPTION	CCPOA
	D2782	◆	Crown - 3/4 cast noble metal	$50
	D2790	◆	Crown - full cast high noble metal	$50
	D2791		Crown - full cast predominantly base metal	$50
	D2792	◆	Crown - full cast noble metal	$50
	D2794	◆	Crown - titanium	$50
OTHER RESTORATIVE SERVICES				
	D2910		Recement inlay, onlay, or partial coverage restoration	$0
	D2915		Recement cast or prefabricated post and core	$0
	D2920		Recement crown	$0
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2930		Prefabricated stainless steel crown - primary tooth	$0
	D2931		Prefabricated stainless steel crown - permanent tooth	$0
	D2932		Prefabricated resin crown	$0
	D2940		Sedative filling	$0
	D2950		Core buildup, involving and including any pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post and core in addition to crown, indirectly fabricated	$0
	D2953		Each additional indirectly fabricated post - same tooth	$40
	D2954		Prefabricated post and core in addition to crown	$0
	D2957		Each additional prefabricated post - same tooth	$0
	D2970		Temporary crown (fractured tooth) - palliative treatment only	$0
			Porcelain on molar restorations (additional charge)	$75 per unit
			Noble metal, high noble metal, and titanium (additional charge)	$75 per unit
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0
ENDODONTIC THERAPY ON PRIMARY TEETH				
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$20
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$30
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$30
	D3332		Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$20
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$20
	D3347		Retreatment of previous root canal therapy - premolar	$30
	D3348		Retreatment of previous root canal therapy - molar	$30
APEXIFICATION/ RECALCIFICAT				
	D3351		Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3352		Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3353		Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair or perforations, root resorption, etc.)	$0
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$0
	D3421		Apicoectomy premolar (first root)	$0
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0
	D3426		Apicoectomy (each additional root)	$0
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$0
	D3472		Surgical repair of root resorption-premolar	$0
	D3473		Surgical repair of root resorption-molar	$0
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$0

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ADA CODE			* ADA DESCRIPTION	CCPOA
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$0
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$0
OTHER ENDODONTIC PROCEDURES				
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$0
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$20
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$20
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$20
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$150
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
	D4355		Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$0
OTHER PERIODONTAL SERVICES				
	D4921		Gingival irrigation with a medicinal agent - per quadrant	$20
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$65
	D5120		Complete denture - mandibular	$65
	D5130		Immediate denture - maxillary	$65
	D5140		Immediate denture - mandibular	$65
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$60
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$60
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$60
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$60
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$60
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$60
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$60
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$60
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$50
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$50
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$50
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$50
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$0
	D5411		Adjust complete denture - mandibular	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	CCPOA
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair or replace broken clasp- per tooth	$0
	D5640		Replace broken teeth - per tooth	$0
	D5650		Add tooth to existing partial denture	$0
	D5660		Add clasp to existing partial denture - per tooth	$0
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$20
	D5711		Rebase complete mandibular denture	$20
	D5720		Rebase maxillary partial denture	$20
	D5721		Rebase mandibular partial denture	$20
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline complete maxillary denture (laboratory)	$15
	D5751		Reline complete mandibular denture (laboratory)	$15
	D5760		Reline maxillary partial denture (laboratory)	$15
	D5761		Reline mandibular partial denture (laboratory)	$15
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5820		Interim partial denture (maxillary)	$40
	D5821		Interim partial denture (mandibular)	$40
	D5850		Tissue conditioning, maxillary	$0
	D5851		Tissue conditioning, mandibular	$0
	D5862		Precision attachment, by report	$410
	D5867		Replacement of replaceable part of semi-precision or precision attachment (male or female component)	$225
	D5875		Modification of removable prosthesis following implant surgery	$311
MAXILLOFACIAL PROSTHETICS				
	D5982		Surgical stent	$269
IMPLANT SERVICES				
	D6010	@	Surgical placement of implant body: endosteal implant	$1,169
	D6053		Implant/abutment supported removable denture for completely edentulous arch	$1,080
	D6055		Dental implant supported connecting bar	$990
	D6056		Prefabricated abutment - includes placement	$383
	D6057		Custom abutment - includes placement	$473
	D6058	@	Abutment supported porcelain/ceramic crown	$711
	D6059	@	Abutment supported porcelain fused to metal crown (high noble metal)	$719
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$621
	D6061	@	Abutment supported porcelain fused to metal crown (noble metal)	$671
	D6062	@	Abutment supported cast metal crown (high noble metal)	$719
	D6065	@	Implant supported porcelain/ceramic crown	$801
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$780
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$757
	D6080		Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$149

	ADA CODE		* ADA DESCRIPTION	CCPOA
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0
	D6090		Repair implant supported prosthesis, by report	$494
	D6091		Replacement of replaceable part og semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$359
	D6092		Recement implant/abutment supported crown	$89
	D6093		Recement implant/abutment supported fixed partial denture	$131
	D6094	@	Abutment supported crown - (titanium)	$719
	D6095		Repair implant abutment, by report	$359
	D6100		Implant removal, by report	$449
	D6191		Semi-precision abutment - placement	$719
	D6192		Semi-precision attachment - placement	$719
	D6199		Unspecified implant procedure, by report	$338
			Porcelain on molar restorations (additional charge)	$75 per unit
			Noble metal, high noble metal, and titanium (additional charge)	$75 per unit
FIXED PARTIAL DENTURE PONTICS				
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$50
	D6210	◆	Pontic - cast high noble metal	$50
	D6211		Pontic - cast predominantly base metal	$50
	D6212	◆	Pontic - cast noble metal	$50
	D6214	◆	Pontic - titanium	$50
	D6240	◆	Pontic - porcelain fused to high noble metal	$50
	D6241		Pontic - porcelain fused to predominantly base metal	$50
	D6242	◆	Pontic - porcelain fused to noble metal	$50
	D6243	◆	Pontic - porcelain fused to titanium or titanium alloys	$50
	D6250	◆	Pontic - resin with high noble metal	$0
	D6251		Pontic - resin with predominantly base metal	$0
	D6252	◆	Pontic - resin with noble metal	$0
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$25
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6710		Crown - indirect resin based composite	$50
	D6720	◆	Crown - resin with high noble metal	$0
	D6721		Crown - resin with predominantly base metal	$0
	D6722	◆	Crown - resin with noble metal	$0
	D6750	◆	Crown - porcelain fused to high noble metal	$50
	D6751		Crown - porcelain fused to predominantly base metal	$50
	D6752	◆	Crown - porcelain fused to noble metal	$50
	D6753	◆	Retainer crown - porcelain fused to titanium or titanium alloys	$50
	D6780	◆	Crown - 3/4 cast high noble metal	$50
	D6781		Crown - 3/4 cast predominantly base metal	$50
	D6782	◆	Crown - 3/4 cast noble metal	$50
	D6784	◆	Retainer crown 3/4 - titaninium and titanium alloys	$50
	D6790	◆	Crown - full cast high noble metal	$50
	D6791		Crown - full cast predominantly base metal	$50
	D6792	◆	Crown - full cast noble metal	$50
	D6794	◆	Crown - titanium	$50
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
	D6940		Stress breaker	$0
	D6980		Fixed partial denture repair, by report	$0
			Porcelain on molar restorations (additional charge)	$75 per unit
			Noble metal, high noble metal, and titanium (additional charge)	$75 per unit
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$0
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	CCPOA
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0
	D7220		Removal of impacted tooth - soft tissue	$0
	D7230		Removal of impacted tooth - partially bony	$0
	D7240		Removal of impacted tooth - completely bony	$0
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$10
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0
OTHER SURGICAL PROCEDURES				
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0
	D7451		Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	$0
EXCIXION OF BONE TISSUE				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
	D7472		Removal of torus palatinus	$0
	D7473		Removal of torus mandibularis	$0
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization	$0
	D7961		Buccal/labial frenectomy	$0
	D7962		Lingual frenectomy	$0
	D7963		Frenuloplasty	$0
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,000
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,000
	D8090		Comprehensive orthodontic treatment of the adult dentition	$1,000
OTHER ORTHODONTIC SERVICES				
	D8660		Pre-orthodontic treatment visit	$25
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$0
			Start up fees	$250
			Ortho visits beyond 24 months active treatment or retention	$25
UNCLASSIFIED TREATMENT				
	D9110		Palliative treatment of dental pain - per visit	$0
ANESTHESIA				
	D9210		Local anesthesia not in conjunction with operative or surgical procedures	$0
	D9211		Regional block anesthesia	$0
	D9215		Local anesthesia	$0
	D9222		Deep sedation/general anesthesia - first 15 minutes	$150
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$150
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$150
	D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$150
PROFESSIONAL CONSULTATION				
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	CCPOA
PROFESSIONAL VISITS				
	D9430		Office visit for observation (during regularly scheduled hours) - no other services performed	$0
	D9440		Office visit, after regularly scheduled hours	$0
			Unspecified adjunctive procedure, by report - includes failed appointment without 24 hour notice	$5
MISCELLANEOUS SERVICES				
	D9932		Cleaning and inspection of removable complete denture, maxillary	$0
	D9933		Cleaning and inspection of removable complete denture, mandibula	$0
	D9934		Cleaning and inspection of removable partial denture maxillary	$0
	D9935		Cleaning and inspection of removable partial denture, mandibula	$0
NON CLINICAL PROCEDURES				
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9997		Dental case management - patients with special health care needs	$0
			Zoom Whitening	$199
			Clear Braces (in addition to orthodontic treatment)	$335
			Invisalign (total copayment)	$3500

FOOTNOTES

@ Where available

CDT 2024

CCPOA Limitations and Exclusions

1. LIMITATION OF BENEFITS
    a. Limitations on Diagnostic and Preventive Benefits:
        (1) Prophylaxis (cleanings), are limited to two treatments in any 12 consecutive months.
        (2) Sealants are only covered to the age of 18 and are limited to permanent first and second molars only.
        (3) Fluoride treatments are a covered benefit up to the age of 18, once every 12 months.
        (4) Full mouth x-rays are limited to one set every 24 consecutive months.
        (5) Bite-wing x-rays are limited to not more than one series of four films in any six-month period.
        (6) Replacement of a restoration is covered only when it is Medically Necessary.

    b. Limitation on Basic Benefits:
        (1) Periodontal treatments (subgingival curettage and root planning) are limited to five (5) quadrants in any 12 consecutive months.

    c. Limitation on Crowns, Jackets, and Cast Restorations:
        (1) Crowns, jackets and cast restorations on the same tooth are limited to once every three (3) years.
        (2) If porcelain or composite is used on molar crowns, the member is responsible for an additional $75 above the set crown copayment.
        (3) If noble or high noble metal is used on crowns, the member is responsible for an additional $75 above the set crown copayment.

    d. Limitation on Prosthodontic Benefits:
        (1) Full upper and/or lower dentures are not to exceed one each in any three (3) year period. Replacement will be provided for an existing denture or bridge if it is unsatisfactory and cannot be made satisfactory.
        (2) Partial dentures are not to be replaced within any three (3) year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
        (3) Denture relines are limited to one during any 12 consecutive months.

e. Limitations and Exclusions on Orthodontic Benefits:
    (1) Orthodontic treatment must be provided by a Western Dental network orthodontist.
    (2) Benefits cover 24 months of usual and customary orthodontic treatment.
    (3) The copayment for orthodontic treatment does not include start-up fees. Start-up fees shall not exceed $250. All covered persons are eligible for orthodontic treatment.
    (4) Start-up fees shall consist of the initial examination, diagnosis and consultation, and the retention phase of treatment, of up to two (2) years maximum. This includes initial construction, placement and adjustments to retainers for a maximum period of two (2) years.
    (5) Surgical procedures, including extractions, are not included as a covered benefit.
    (6) There are no benefits for stolen, lost, or broken appliances.
    (7) Cephalometric x-rays, tracings, photographs, and study models are not included as a benefit.
    (8) Myofunctional therapy.
    (9) Surgical procedures related to cleft palate, micrognathia or macrognathia.
    (10) Treatment related to Temporomandibular Joint (T.M.J.) disturbances and/or hormonal imbalance.
    (11) Any dental procedure considered within the field of general dentistry such as fillings or extractions.
    (12) Malocclusions which are so severe or mutilated so as not to be amenable to ideal orthodontic therapy.
    (13) Treatment that extends 24 months beyond the point of full permanent dentition will be subject to an office visit charge of $25 per office visit.
    (14) Tooth guidance appliances
    (15) Crown exposure and ligation.
    (16) If a member relocates to an area and is unable to receive treatment from a Participating Orthodontist, coverage under this program ceases and it becomes the obligation of the member to pay the usual and customary fee of the orthodontist where the treatment is completed.

Additional charges (at the Orthodontist's Usual and Customary Fee) will be made for:

1. Initial diagnostic work up and x-rays.
2. Cephalometric x-rays and tracings.
3. Photographs.
4. Study models.
5. Extractions for orthodontic purposes.
6. Pre-banding devices, appliances or therapy.
7. Tooth guidance appliances.
8. Crown and exposure ligation.

9. Orthodontic consultation if the member does not accept treatment plan.
10. Missed appointments (without 24 hours notice).
11. Lost or broken bands.
12. Lost or broken headgear.
13. Headgear.
14. Retainers after the 24 months treatment period has expired.
15. Gross non-cooperation.

2. EXCLUSION OF BENEFITS

The following services are not covered benefits:

a. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services, which are provided to the enrollee by State government, or agency thereof, are provided without cost to the enrollee by any municipality, county or other subdivisions.
b. Elective or cosmetic dental care.
c. Temporomandibular Joint (T.M.J.).
d. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or extraction solely for orthodontic purposes.
e. Treatment of malignancies, cysts, neoplasms, or congenital malformations.
f. Hospital charges of any kind.
g. Loss or theft of dentures or bridgework.
h. Dispensing of drugs not normally supplied in a dental office.
i. General anesthesia and the services of a special anesthesiologist.
j. Treatment required by reason of war.
k. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
l. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
m. Any service that is not specifically listed as a covered expense.
n. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limits of the enrollee.
o. Fees incurred for missed appointment or failure to notify panel dentist of cancellation 24 hours prior to appointment.
p. Any procedure of an experimental nature.
q. Services which are reimbursable by insurance or reimbursable under any other group or health service plans. Services shall be provided at the time of need, but the member shall execute such documents as necessary to assure reimbursement for such benefits.
r. Any procedure performed for the purpose of correcting contour, contact or occlusion. Any procedure to correct tooth structure lost due to attrition, erosion or abrasion.
s. A Participating Dentist may refuse treatment to any member who continually fails to follow a prescribed course of treatment.
t. If the member and Participating Dentist elect a treatment plan disallowed by Western Dental, further liability for additional treatment on that tooth/teeth will not be assumed.

STATE OF CA

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
CLINICAL ORAL EVALUATIONS				
	D0120		Periodic oral examination - established patient	$0
	D0140		Limited oral evaluation - problem focused	$0
	D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
	D0150		Comprehensive oral evaluation - new or established patient	$0
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
	D0171		Re-evaluation - post operative office visit	$0
	D0180		Comprehensive periodontal evaluation - new or established patient	$0
	D0190		Screening of a patient	$0
	D0191		Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)				
	D0210		Intraoral comprehensive series of radiographic images	$0
	D0220		Intraoral - periapical radiographic image	$0
	D0230		Intraoral - periapical each additional film	$0
	D0240		Intraoral - occlusal radiographic	$0
	D0251		Extraoral - posterior dental radiographic image	$0
	D0250		Extra-oral single film	$0
	D0260		Extraoral - each additional film	$0
	D0270		Bitewing - single film	$0
	D0272		Bitewings - two films	$0
	D0273		Bitewings—three radiographic images	$0
	D0274		Bitewings - four films	$0
	D0277		Vertical bitewings - 7 to 8 films	$0
	D0330		Panoramic film	$0
	D0340		Cephalometric Film	$0
	D0350		Oral/Facial Images	$0
	D0351		3D Photographic Image	$0
TESTS AND EXAMINATIONS				
	D0415		Collection of microorganisms for culture and sensitivity	$0
	D0419		Assessment of salivary flow by measurement	$0
	D0425		Caries susceptibility tests	$0
	D0470		Diagnostic casts	$0
	D0460		Pulp vitality tests	$0
	D0601		Caries risk assessment and documentation, with a finding of low risk	$0
	D0602		Caries risk assessment and documentation, with a finding of moderate risk	$0
	D0603		Caries risk assessment and documentation, with a finding of high risk	$0
	D0701		Panoramic radiographic image- image capture only	$0
	D0702		2-D cephalometric radiographic- image capture only	$0
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
	D0705		extra-oral posterior dental radiographic image capture only	$0
	D0706		intraoral- occlusal radiographic image- image capture only	$0
	D0707		intraoral- periapical radiographic image- image capture only	$0

	ADA CODE		* ADA DESCRIPTION	STCAEM
	D0708		intraoral- bitewing radiographic image- image capture only	$0
	D0709		intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY				
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - adult	$0
	D1120		Prophylaxis - child	$0
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1320		Tobacco counseling for the control and prevention of oral diseas	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
	D1355		caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0
	D1557		Removal of fixed bilateral space maintainer maxillary	$0
	D1558		Removal of fixed bilateral space maintainer mandibular	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-based composite - one surface, posterior	$40
	D2392		Resin-based composite - two surfaces, posterior	$50
	D2393		Resin-based composite - three surfaces, posterior	$60
	D2394		Resin-based composite - four or more surfaces, posterior	$70
INLAY/ONLAY RESTORATIONS				
	D2510	◆	Inlay - metallic - one surface	$50
	D2520	◆	Inlay - metallic - two surface	$50
	D2530	◆	Inlay - metallic - three or more surfaces	$50
	D2542	◆	Onlay - metallic - two surfaces	$50
	D2543	◆	Onlays - metallic - three surfaces	$50
	D2544	◆	Onlays - metallic - four or more surfaces	$50
	D2610	◆	Inlay - porcelain/ceramic - one surface	$460
	D2620	◆	Inlay - porcelain/ceramic - two surfaces	$395
	D2630	◆	Inlay - porcelain/ceramic - three or more surfaces	$450
	D2642	◆	Onlay - porcelain/ceramic - two surfaces	$585
	D2643	◆	Onlay - porcelain/ceramic - three surfaces	$575
	D2644	◆	Onlay - porcelain/ceramic - four or more surfaces	$605
	D2650	◆	Inlay - resin-based composite - one surface	$309
	D2651	◆	Inlay - resin-based composite - two surfaces	$415
	D2652	◆	Inlay - resin-based composite - three or more surfaces	$415
	D2662	◆	Onlay - resin-based composite - two surfaces	$560
	D2663	◆	Onlay - resin-based composite - three surfaces	$530
	D2664	◆	Onlay - resin-based composite - four or more surfaces	$530
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect)	$50
	D2712		Crown - 3/4 resin-based composite (indirect)	$50
	D2720	◆	Crown - resin with high noble metal	$50
	D2721		Crown - resin with predominantly base metal	$50
	D2722	◆	Crown - resin with noble metal	$50
	D2740		Crown - porcelain/ceramic	$50
	D2750	◆	Crown - porcelain fused to high noble metal	$50
	D2751		Crown - porcelain fused to predominantly base metal	$50
	D2752	◆	Crown - porcelain fused to noble metal	$50
	D2753	◆	Crown- porcelain fused to titanium or titanium alloy	$50
	D2780	◆	Crown - 3/4 cast high noble metal	$50
	D2781		Crown - 3/4 cast predominantly base metal	$50
	D2782	◆	Crown - 3/4 cast noble metal	$50
	D2783	◆	Crown - 3/4 porcelain/ceramic (2)	$50
	D2790	◆	Crown - full cast high noble metal	$50
	D2791		Crown - full cast predominantly base metal	$50
	D2792	◆	Crown - full cast noble metal	$50
	D2794	◆	Crown - titanium	$50
OTHER RESTORATIVE SERVICES				

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
	D2910		Re-cement or re-bond inlay, onlay, veneer or partial cover- age	$0
	D2915		Recement cast or prefabricated post and core	$0
	D2920		Recement crown	$0
	D2921		Reattachment of tooth fragment, incisal edge or cusp	$0
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2929		Prefabricated porcelain/ceramic crown – primary tooth	$200
	D2930		Prefabricated stainless steel crown - primary tooth	$0
	D2931		Prefabricated stainless steel crown - permanent tooth	$0
	D2932		Prefabricated resin crown	$0
	D2933		Prefabricated stainless steel crown with resin window	$205
	D2940		Sedative filling	$0
	D2941		Interim therapeutic restoration – primary dentition	$0
	D2950		Core buildup, involving and including any pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post and core in addition to crown, indirectly fabricated	$0
	D2953		Each additional indirectly fabricated post - same tooth	$40
	D2954		Prefabricated post and core in addition to crown	$0
	D2957		Each additional prefabricated post - same tooth	$0
			Porcelain on molar restorations (additional charge)	$75 per unit
			Noble metal, high noble metal, and titanium (additional charge)	$75 per unit
	D2949		Restorative foundation for an indirect restoration	$90
	D2971		Additional procedures to construct new crown under existing partial	$80
	D2980		Crown repair necessitated by restorative material failure	$145
	D2981		Inlay repair necessitated by restorative material failure	$85
	D2982		Onlay repair necessitated by restorative material failure	$195
	D2983		Veneer repair necessitated by restorative material failure	$130
	D2990		Resin infiltration of incipient smooth surface lesions	$0
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0
	D3221		Pulpal debridement, primary and permanent teeth	$110
	D3222		Partial pulpotomy for apexogenesis - permanent tooth with incomplete	$0
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding	$0
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth	$0
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$20
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$40
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$60
	D3331		Treatment of root canal obstruction; non-surgical access	$215
	D3332		Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$20
	D3333		Internal root repair of perforation defects	$190
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$20
	D3347		Retreatment of previous root canal therapy - premolar	$40
	D3348		Retreatment of previous root canal therapy - molar	$60
APEXIFICATION/RECALCIFICATION				

Schedule of Benefits

	ADA CODE		* ADA DESCRIPTION	STCAEM
	D3351		Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3352		Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	$0
	D3353		Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair or perforations, root resorption, etc.)	$0
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$50
	D3421		Apicoectomy premolar (first root)	$50
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$50
	D3426		Apicoectomy (each additional root)	$50
	D3427		Periradicular surgery without apicoectomy	$50
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$50
	D3472		Surgical repair of root resorption-premolar	$50
	D3473		Surgical repair of root resorption-molar	$50
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$60
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$70
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$80
	D3920		Hemisection (including any root removal), not including root canal therapy	$215
OTHER ENDODONTIC PROCEDURES				
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$5
	D4212		Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$0
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$350
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$325
	D4245		Apically positioned flap	$315
	D4249		Clinical crown lengthening – hard tissue	$405
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$150
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$150
	D4263		Bone replacement graft – retained natural tooth – first site in quadrant	$295
	D4264		Bone replacement graft – retained natural tooth – each additional site in quadrant	$235

	ADA CODE		* ADA DESCRIPTION	STCAEM
	D4270		Pedicle soft tissue graft procedure	$475
	D4274		Mesial/distal wedge procedure, single tooth (when not per- formed in conjunction with surgical procedures in the same anatomical area)	$350
	D4277		Free soft tissue graft procedure (including recipient and do- nor surgical sites) first tooth, implant or edentulous tooth po- sition in graft	$580
	D4278		Free soft tissue graft procedure (including recipient and do- nor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$400
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
	D4355		Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$0
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal maintenance	$80
			Additional periodontal maintenance (within the 6 month period)	$80
	D4921		Gingival Irrigation with a medicinal agent - Per quadrant	$40
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$65
	D5120		Complete denture - mandibular	$65
	D5130		Immediate denture - maxillary	$65
	D5140		Immediate denture - mandibular	$65
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$65
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$65
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$65
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$65
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$65
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$65
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$65
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps0	$65
	D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$685
	D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$720

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$50
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$50
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$50
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$50
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$0
	D5411		Adjust complete denture - mandibular	$0
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair or replace broken clasp- per tooth	$0
	D5640		Replace broken teeth - per tooth	$0
	D5650		Add tooth to existing partial denture	$0
	D5660		Add clasp to existing partial denture - per tooth	$0
	D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	$365
	D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	$365
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$20
	D5711		Rebase complete mandibular denture	$20
	D5720		Rebase maxillary partial denture	$20
	D5721		Rebase mandibular partial denture	$20
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline complete maxillary denture (laboratory)	$15
	D5751		Reline complete mandibular denture (laboratory)	$15
	D5760		Reline maxillary partial denture (laboratory)	$15
	D5761		Reline mandibular partial denture (laboratory)	$15
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5820		Interim partial denture (maxillary)	$60
	D5821		Interim partial denture (mandibular)	$60
	D5850		Tissue conditioning, maxillary	$0
	D5851		Tissue conditioning, mandibular	$0
	D5862		Precision attachment, by report	$410
	D5867		Replacement of replaceable part of semi-precision or precision attachment (male or female component)	$225
	D5875		Modification of removable prosthesis following implant surgery	$311

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
MAXILLOFACIAL PROSTHETICS				
	D5982		Surgical stent	$269
IMPLANT SERVICES				
	D6010	@	Surgical placement of implant body: endosteal implant	$1,169
	D6055		Dental implant supported connecting bar	$990
	D6056		Prefabricated abutment - includes placement	$383
	D6057		Custom abutment - includes placement	$473
	D6058	@	Abutment supported porcelain/ceramic crown	$711
	D6059	@	Abutment supported porcelain fused to metal crown (high noble metal)	$719
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$621
	D6061	@	Abutment supported porcelain fused to metal crown (noble metal)	$671
	D6062	@	Abutment supported cast metal crown (high noble metal)	$719
	D6065	@	Implant supported porcelain/ceramic crown	$801
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$780
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$757
	D6080		Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$149
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$0
	D6090		Repair implant supported prosthesis, by report	$494
	D6091		Replacement of replaceable part og semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$359
	D6092		Recement implant/abutment supported crown	$89
	D6093		Recement implant/abutment supported fixed partial denture	$131
	D6094	@	Abutment supported crown - (titanium)	$719
	D6095		Repair implant abutment, by report	$359
	D6100		Implant removal, by report	$449
	D6110		Implant/abutment supported removable denture for edentulous arch - maxillary	$1080
	D6111		Implant/abutment supported removable denture for edentulous arch - mandibular	$1080
	D6191		Semi-precision abutment - placement	$719
	D6192		Semi-precision attachment - placement	$719
	D6199		Unspecified implant procedure, by report	$338
FIXED PARTIAL DENTURE PONTICS				
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$50
	D6210	◆	Pontic - cast high noble metal	$50
	D6211		Pontic - cast predominantly base metal	$50
	D6212	◆	Pontic - cast noble metal	$50
	D6214	◆	Pontic - titanium	$50
	D6240	◆	Pontic - porcelain fused to high noble metal	$50
	D6241		Pontic - porcelain fused to predominantly base metal	$50
	D6242	◆	Pontic - porcelain fused to noble metal	$50
	D6243	◆	Pontic - porcelain fused to titanium and titanium alloys (1) (2)	$50

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	ADA CODE		* ADA DESCRIPTION	STCAEM
	D6245		Pontic - porcelain/ceramic (2)	$50
	D6250	◆	Pontic - resin with high noble metal	$0
	D6251		Pontic - resin with predominantly base metal	$0
	D6252	◆	Pontic - resin with noble metal	$0
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$50
	D6549		D6549 Retainer – for resin bonded fixed prosthesis	$50
	D6600		D6600 Retainer inlay - porcelain/ceramic, two surfaces	$505
	D6601		D6601 Retainer inlay - porcelain/ceramic, three or more surfaces	$565
	D6602		D6602 Retainer inlay - cast high noble metal, two surfaces	$450
	D6603		Retainer inlay - cast high noble metal, three or more surfaces	$500
	D6604		Retainer inlay - cast predominantly base metal, two surfaces	$435
	D6605		Retainer inlay - cast predominantly base metal, three or more	$475
	D6606		Retainer inlay - cast noble metal, two surfaces	$310
	D6607		Retainer inlay - cast noble metal, three or more surfaces	$490
	D6608		Retainer onlay - porcelain/ceramic, two surfaces	$525
	D6609		Retainer onlay - porcelain/ceramic, three or more surfaces	$575
	D6610		Retainer onlay - cast high noble metal, two surfaces	$50
	D6611		Retainer onlay - cast high noble metal, three or more surfaces	$50
	D6612		Retainer onlay - cast predominantly base metal, two surfaces	$425
	D6613		Retainer onlay - cast predominantly base metal, three or more	$545
	D6614		Retainer onlay - cast noble metal, two surfaces	$595
	D6615		Retainer onlay - cast noble metal, three or more surfaces	$555
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6710		Crown - indirect resin based composite	$50
	D6720	◆	Crown - resin with high noble metal	$0
	D6721		Crown - resin with predominantly base metal	$0
	D6722	◆	Crown - resin with noble metal	$0
	D6740		Retainer crown - porcelain/ceramic	$615
	D6750	◆	Crown - porcelain fused to high noble metal	$50
	D6751		Crown - porcelain fused to predominantly base metal	$50
	D6752	◆	Crown - porcelain fused to noble metal	$50
	D6753	◆	Retainer crown - porcelain fused to titanium or titanium alloys	$50
	D6780	◆	Crown - 3/4 cast high noble metal	$50
	D6781		Crown - 3/4 cast predominantly base metal	$50
	D6782	◆	Crown - 3/4 cast noble metal	$50
	D6783		Retainer crown - 3/4 porcelain/ceramic	$635
	D6784	◆	Retainer crown 3/4 - titaninium and titanium alloys	$50
	D6790	◆	Crown - full cast high noble metal	$50
	D6791		Crown - full cast predominantly base metal	$50
	D6792	◆	Crown - full cast noble metal	$50
	D6794	◆	Crown - titanium	$50
			Porcelain on molar restorations (additional charge)	$75 per unit
			Noble metal, high noble metal, and titanium (additional charge)	$75 per unit
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
	D6940		Stress breaker	$0
	D6980		Fixed partial denture repair, by report	$0
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
	D7111		Extraction, coronal remnants - primary tooth	$0
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$0
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0
	D7220		Removal of impacted tooth - soft tissue	$0
	D7230		Removal of impacted tooth - partially bony	$0
	D7240		Removal of impacted tooth - completely bony	$0
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$15
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$15
	D7251		Coronectomy – intentional partial tooth removal, impacted teeth only	$15
OTHER SURGICAL PROCEDURES				
	D7270		Tooth reimplantation and/or stabilization of accidentally	$290
	D7280		Exposure of an unerupted tooth	$305
	D7282		Mobilization of erupted or malpositioned tooth to aid eruption	$185
	D7283		Placement of device to facilitate eruption of impacted tooth	$185
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0
	D7451		Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	$0
EXCISION OF BONE TISSUE				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
	D7472		Removal of torus palatinus	$0
	D7473		Removal of torus mandibularis	$0
	D7510		Incision and drainage of abscess - intraoral soft tissue	$135
	D7970		Excision of hyperplastic tissue - per arch	$360
	D7971		Excision of pericoronal gingiva	$170
SURGICAL INCISION				
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0
	D7961		buccal/labial frenectomy	$0
	D7962		lingual frenectomy	$0
	D7963		Frenuloplasty	$0
ORTHODONTICS				
	D8010		Limited orthodontic treatment of the primary dentition	$965
	D8020		Limited orthodontic treatment of the transitional dentition	$1020

Schedule of Benefits

ADA CODE			* ADA DESCRIPTION	STCAEM
	D8030		Limited orthodontic treatment of the adolescent dentition	$1195
	D8040		Limited orthodontic treatment of the adult dentition	$1240
	D8050		Interceptive orthodontic treatment of the primary dentition	$1110
	D8060		Interceptive orthodontic treatment of the transitional denti-	$1285
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,000
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,000
	D8090		Comprehensive orthodontic treatment of the adult dentition	$1,000
OTHER ORTHODONTIC SERVICES				
	D8660		Pre-orthodontic treatment visit	$25
	D8670		Periodic orthodontic treatment visit	$235
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$0
			Start up fees	$250
			Ortho visits beyond 24 months active treatment or retention	$25/visit
	D8681		Removable orthodontic retainer adjustment	$50
	D8999		Unspecified orthodontic procedure, by report (Includes treatment planning and report)	$250
UNCLASSIFIED TREATMENT				
	D9110		Palliative treatment of dental pain - per visit	$0
ANESTHESIA				
	D9210		Local anesthesia not in conjunction with operative or surgical procedures	$0
	D9211		Regional block anesthesia	$0
	D9212		Trigeminal division block anesthesia	$0
	D9215		Local anesthesia	$0
	D9219		Evaluation for moderate sedation, deep sedation or general anesthesia	$0
	D9222		Deep sedation/general anesthesia - first 15 minutes	$120
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$120
	D9239		Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	$115
	D9243		Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$115
PROFESSIONAL CONSULTATION				
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
	D9311		Consultation with a medical health care professional	$0
PROFESSIONAL VISITS				
	D9430		Office visit for observation (during regularly scheduled hours) - no other services performed	$0
	D9440		Office visit, after regularly scheduled hours	$0
	D9450		Case presentation, detailed and extensive treatment planning	$105
MISCELLANEOUS SERVICES				
	D9932		Cleaning and inspection of removable complete denture, maxilla	$0
	D9933		Cleaning and inspection of removable complete denture, mandib	$0
	D9934		Cleaning and inspection of removable partial denture maxillary	$0
	D9935		Cleaning and inspection of removable partial denture, mandibula	$0

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	ADA CODE		* ADA DESCRIPTION	STCAEM
	D9943		Occlusal guard adjustment	$75
	D9944		Occlusal guard – hard appliance, full arch	$275
	D9945		Occlusal guard – soft appliance, full arch	$275
	D9946		Occlusal guard – hard appliance, partial arch	$275
	D9951		Occlusal adjustment - limited	$80
	D9952		Occlusal adjustment - complete	$235
	D9972		External bleaching - per arch - take home trays	$120
	D9975		External bleaching for home application, per arch; includes materials and fabrication of custom trays	$120
	NON CLINICAL PROCEDURES			
	D9986		Missed appointment	$5
	D9987		Cancelled appointment	$5
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9991		Dental case management – addressing appointment compliance	$0
	D9992		Dental case management – care coordination	$0
	D9995		Teledentistry – synchronous; real-time encounter	$0
	D9996		Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0
	D9997		Dental case management - patients with special health care needs	$0

FOOTNOTES

@ Where available

◆ Metal charges apply to a maximum of $125

(1) Additional charge for noble, high noble metal and titanium $75 per unit

(2) Porcelain on molar restorations $75 unit

CDT 2024

STCAEM Provider Minimum Guarantee

ADA	Description	Minimum Guarantee
D0210	intraoral - complete series of radiographic images	$ 10.00
D0330	Panographic radiographic image	$ 10.00
D1110	Prophylaxis - adult	$ 10.00
D1120	Prophylaxis - child	$ 10.00
D1351	sealant - per tooth	$ 10.00
D2140	amalgam - one surface, primary or permanent	$ 5.00
D2150	amalgam - two surfaces, primary or permanent	$ 10.00
D2160	amalgam - three surfaces, primary or permanent	$ 10.00
D2161	amalgam - four or more surfaces, primary or permanent	$ 15.00
D2330	resin-based composite - one surface, anterior	$ 10.00
D2331	resin-based composite - two surfaces, anterior	$ 15.00
D2332	resin-based composite - three surfaces, anterior	$ 15.00
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$ 20.00
D2390	Resin - Composite Crown (Anterior)	$ 20.00
D2542	Onlay - Metallic - Two surfaces	$ 85.00
D2543	Onlay - Metallic - Three surfaces	$ 85.00
D2544	Onlay - Metallic - Four or more surfaces	$ 85.00
D2710	Crown - resin - based compisite (indirect)	$ 70.00
D2712	Crown - 3/4 resin - base composite (indirect)	$ 70.00
D2720	Crown - Resin high noble metal	$ 210.00
D2721	Crown - Resin base metal	$ 160.00
D2722	Crown - Resin noble metal	$ 175.00
D2780	Crown - 3/4 cast high noble metal	$ 210.00
D2781	Crown - 3/4 cast predominantly base metal	$ 160.00
D2782	Crown - 3/4 cast noble metal	$ 210.00
D2790	crown - full cast high noble metal	$ 210.00
D2791	crown - full cast predominantly base metal	$ 65.00
D2792	crown - full cast noble metal	$ 140.00
D2794	Crown - titanium and titanium alloys	$ 140.00
D2930	Prefabricated stainless steel crown - primary tooth	$ 10.00
D2931	Prefabricated stainless steel crown - permanent tooth	$ 10.00
D2952	Post and core in addition to crown indirectly fabricated	$ 50.00
D2954	Prefabricated post and core in addition to crown	$ 50.00
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$ 20.00
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$ 40.00
D3330	endodontic therapy, molar (excluding final restoration)	$ 190.00
D3346	Retreatment of previous root canal therapy - anterior	$ 20.00
D3347	Retreatment of previous root canal therapy - premolar	$ 40.00
D3348	Retreatment of previous root canal therapy - molar	$ 190.00
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$ 15.00
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$ 5.00
D4355	Full mouth debridement to enable a comprehensice oral evaluation and diagnosis on a subsequent visit	$ 20.00
D5110	complete denture - maxillary	$ 265.00
D5120	complete denture - mandibular	$ 265.00

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D5130	immediate denture - maxillary	$	290.00
D5140	immediate denture - mandibular	$	290.00
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$	185.00
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$	185.00
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$	295.00
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$	295.00
D5710	Rebase complete maxillary denture	$	60.00
D5711	Rebase complete mandubular denture	$	60.00
D5720	Rebase maxillary partial denture	$	50.00
D5721	Rebase mandibular partial denture	$	50.00
D5750	Reline complete maxillary denture (laboratory)	$	65.00
D5751	Reline complete mandibular denture (laboratory)	$	65.00
D5760	Reline maxillary partial denture (laboratory)	$	55.00
D5761	Reline mandibular partial denture (laboratory)	$	55.00
D6205	Pontic - indirect resin based composite	$	145.00
D6210	Pontic - cast high noble metal	$	170.00
D6211	Pontic - cast predominantly base metal	$	125.00
D6212	Pontic - cast noble metal	$	170.00
D6214	Pontic - Titanium	$	125.00
D6240	Pontic - Porcelain fused to high noble metal	$	170.00
D6241	Pontic - Porcelain fused to predominantly base metal	$	120.00
D6242	Pontic - Porcelain fused to noble metal	$	170.00
D6250	Pontic - Resin high noble metal	$	295.00
D6251	Pontic - Resin base metal	$	295.00
D6252	Pontic - Resin noble metal	$	295.00
D6710	Retainer crown - indirect resin based composite	$	145.00
D6720	Abutment - Resin high noble metal	$	260.00
D6721	Abutment - Resin base metal	$	210.00
D6722	Abutment - Resin noble metal	$	260.00
D6750	Retainer crown - porcelain fused to high noble metal	$	210.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$	155.00
D6752	Retainer crown - porcelain fused to noble metal	$	210.00
D6780	Retainer crown - 3/4 cast high noble metal	$	210.00
D6781	Retainer crown - 3/4 cast perdominantly base metal	$	155.00
D6782	Retainer crown - 3/4 cast noble metal	$	210.00
D6790	Retainer crown - full cast high noble metal	$	210.00
D6791	Retainer crown - full cast predominantly base metal	$	155.00
D6792	Retainer crown - full cast noble metal	$	210.00
D6794	Crown - Titanium	$	115.00
D6972	Prefab post and core - In add to FPD Retainer	$	50.00
D7210	Extraction erupted tooth req removal of bone and/ or sectioning of tooth incl. elevt.	$	20.00
D7220	Removal of impacted tooth - soft tissue	$	35.00
D7230	Removal of impacted tooth - partially bony	$	40.00
D7240	Removal of impacted tooth - completely bony	$	45.00
D7250	Removal of residual tooth roots (cutting procedure)	$	30.00

CURRENT STANDARD PLAN LIMITATIONS & EXCLUSIONS

1. LIMITATION OF BENEFITS

a. Limitations on Diagnostic and Preventive Benefits:

(1) Prophylaxis (cleanings), are limited to two treatments in any 12 consecutive months.

(2) Sealants are only covered to the age of 18 and are limited to permanent first and second molars only.

(3) Fluoride treatments are a covered benefit up to the age of 18, once every 12 months.

(4) Full mouth x-rays are limited to one set every 24 consecutive months.

(5) Bite-wing x-rays are limited to not more than one series of four films in any six-month period.

b. Limitation on Basic Benefits:

(1) Periodontal treatments (subgingival curettage and root planning) are limited to five (5) quadrants in any 12 consecutive months.

c. Limitation on Crowns, Jackets, and Cast Restorations:

(1) Crowns, jackets and cast restorations on the same tooth are limited to once every five (5) years.

d. Limitation on Prosthodontic Benefits:

(1) Full upper and/or lower dentures are not to exceed one each in any five-year period. Replacement will be provided for an existing denture or bridge if it is unsatisfactory and cannot be made satisfactory.

(2) Partial dentures are not to be replaced within any five-year period unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.

(3) Denture relines are limited to one during any 12 consecutive months.

e. Limitations and Exclusions on Orthodontic Benefits:

(1) Orthodontic treatment must be provided by a member of the Western Dental orthodontic panel.

(2) Benefits cover 24 months of usual and customary orthodontic treatment.

(3) The copayment for orthodontic treatment does not include start-up fees. Start-up fees shall not exceed $250. All covered persons are eligible for orthodontic treatment.

(4) Start-up fees shall consist of the initial examination, diagnosis and consultation, and the retention phase of treatment, of up to two (2) years maximum. This includes initial construction, placement and adjustments to retainers for a maximum period of two (2) years.

(5) Surgical procedures, including extractions, are not a covered benefit.

(6) There are no benefits for stolen, lost, or broken appliances.

(7) Cephalometric x-rays, tracings, photographs, and study models are not included as a benefit.

2. EXCLUSION OF BENEFITS

The following services are not covered benefits:

a. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable. Services, which are provided to the enrollee by State government, or agency thereof, are provided without cost to the enrollee by any municipality, county or other subdivisions.
b. Elective or cosmetic dental care.
c. Temporomandibular Joint (T.M.J.).
d. Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or extraction solely for orthodontic purposes.
e. Treatment of malignancies, cysts, neoplasms, or congenital malformations.
f. Hospital charges of any kind.
g. Loss or theft of dentures or bridgework.
h. Dispensing of drugs not normally supplied in a dental office.
i. General anesthesia and the services of a special anesthesiologist.
j. Treatment required by reason of war.
k. Dental expenses incurred in connection with any dental procedure started after termination of eligibility for coverage.
l. Any service that is not specifically listed as a covered expense.
m. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limits of the enrollee.
n. Fees incurred for missed appointment or failure to notify panel dentist of cancellation 24 hours prior to appointment.

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Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
CLINICAL ORAL EVALUATIONS				
	D0120		Periodic oral examination - established patient	$0
	D0140		Limited oral evaluation - problem focused	$0
	D0145		Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
	D0150		Comprehensive oral evaluation - new or established patient	$0
	D0160		Detailed and extensive oral evaluation - problem focused, by report	$0
	D0170		Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
	D0171		Re-evaluation - post operative office visit	$0
	D0180		Comprehensive periodontal evaluation - new or established patient	$0
	D0190		Screening of a patient	$0
	D0191		Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)				
	D0210		Intraoral comprehensive series of radiographic images	$0
	D0220		Intraoral - periapical radiographic image	$0
	D0230		Intraoral - periapical each additional film	$0
	D0240		Intraoral - occlusal radiographic	$0
	D0250		Extra-oral single film	$0
	D0270		Bitewing - single film	$0
	D0272		Bitewings - two films	$0
	D0273		Bitewings - three films	$0
	D0274		Bitewings - four films	$0
	D0277		Vertical bitewings - 7 to 8 films	$0
	D0330		Panoramic film	$0
	D0340		Cephalometric Film	$0
	D0350		Oral/Facial Images	$0
TESTS AND EXAMINATIONS				
	D0419		Assement of salivary flow by measurement	$0
	D0460		Pulp vitality tests	$0
	D0470		Diagnostic casts	$0
	D0601		Caries risk assessment and documentation, with a finding of low risk	$0
	D0602		Caries risk assessment and documentation, with a finding of moderate risk	$0
	D0603		Caries risk assessment and documentation, with a finding of high risk	$0
	D0701		Panoramic radiographic image- image capture only	$0
	D0702		2-D cephalometric radiographic- image capture only	$0
	D0703		2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
	D0705		extra-oral posterior dental radiographic image capture only	$0
	D0706		intraoral- occlusal radiographic image- image capture only	$0
	D0707		intraoral- periapical radiographic image- image capture only	$0

	ADA CODE		*ADA DESCRIPTION	EM8820
	D0708		intraoral- bitewing radiographic image- image capture only	$0
	D0709		intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY				
	D0472		Accession of tissue, gross examination, preparation and transmission of written report	$0
	D0473		Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
	D0474		Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
	D0999		Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS				
	D1110		Prophylaxis - adult	$0
			D1110 and D1120 additional prophy exceeding two in a 12 month period	$45
	D1120		Prophylaxis - child	$0
			D1110 and D1120 additional prophy exceeding two in a 12 month period	$45
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1320		Tobacco counseling for the control and prevention of oral diseas	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$0
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
	D1355		caries preventive medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$20
	D1516		Space maintainer - fixed - bilateral - maxillary	$30
	D1517		Space maintainer - fixed - bilateral - mandibular	$30
	D1520		Space maintainer - removable - unilateral	$30
	D1526		Space maintainer - removable - maxillary	$35
	D1527		Space maintainer - removable - mandibular	$35
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$10

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
	D1557		Removal of fixed bilateral space maintainer maxillary	$10
	D1558		Removal of fixed bilateral space maintainer mandibular	$10
	D1575		Distal shoe space maintainer - fixed unilateral	$30
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
	D2390		Resin-based composite crown, anterior	$0
	D2391		Resin-based composite - one surface, posterior	$55
	D2392		Resin-based composite - two surfaces, posterior	$65
	D2393		Resin-based composite - three surfaces, posterior	$75
	D2394		Resin-based composite - four or more surfaces, posterior	$85
INLAY/ONLAY RESTORATIONS				
	D2510	◆	Inlay - metallic - one surface	$50
	D2520	◆	Inlay - metallic - two surfaces	$60
	D2530	◆	Inlay - metallic - three or more surfaces	$60
	D2542	◆	Onlay - metallic - two surfaces	$65
	D2543	◆	Onlays - metallic - three surfaces	$65
	D2544	◆	Onlays - metallic - four or more surfaces	$70
	D2610		Inlay - porcelain/ceramic - 1 surface	$330
	D2620		Inlay - porcelain/ceramic - 2 surfaces	$345
	D2630		Inlay - porcelain/ceramic - 3 or more surfaces	$365
	D2642		Onlay, porcelain/ceramic - 2 surfaces	$355
	D2643		Onlay, porcelain/ceramic - 3 surfaces	$385
	D2651		Inlay - resin-based composite - 2 surfaces	$255
	D2652		Inlay - resin-based composite - 3 or more surfaces	$270
	D2662		Onlay - resin-based composite - 2 surfaces	$235
	D2663		Onlay - resin-based composite - 3 surfaces	$275
CROWNS - SINGLE RESTORATIONS ONLY				
	D2710		Crown - resin-based composite (indirect)	$45
	D2712		Crown - 3/4 resin-based composite (indirect)	$45
	D2720	◆	Crown - resin with high noble metal	$90
	D2721		Crown - resin with predominantly base metal	$90
	D2722	◆	Crown - resin with noble metal	$90
	D2740		Crown - porcelain/ceramic	$105
	D2750	◆	Crown - porcelain fused to high noble metal	$90

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
	D2751		Crown - porcelain fused to predominantly base metal	$90
	D2752	◆	Crown - porcelain fused to noble metal	$90
	D2753	◆	Crown- porcelain fused to titanium or titanium alloy	$90
	D2780	◆	Crown - 3/4 cast high noble metal	$90
	D2781		Crown - 3/4 cast predominantly base metal	$90
	D2782	◆	Crown - 3/4 cast noble metal	$90
	D2783		Crown - 3/4 porcelain/ceramic	$100
	D2790	◆	Crown - full cast high noble metal	$90
	D2791		Crown - full cast predominantly base metal	$90
	D2792	◆	Crown - full cast noble metal	$90
	D2794	◆	Crown - titanium	$90
	D2799		Provisional crown - To be used at least 6 months during healing	$30
OTHER RESTORATIVE SERVICES				
	D2910		Recement inlay, onlay, or partial coverage restoration	$5
	D2915		Recement cast or prefabricated post and core	$5
	D2920		Recement crown	$5
	D2928		prefabricated porcelain/ceramic crown - permanent tooth	$0
	D2930		Prefabricated stainless steel crown - primary tooth	$20
	D2931		Prefabricated stainless steel crown - permanent tooth	$25
	D2932		Prefabricated resin crown	$30
	D2933		Prefabricated stainless steel crown with resin window	$30
	D2934		Prefabricated esthetic coated stainless steel crown - primary tooth	$30
	D2940		Sedative filling	$0
	D2950		Core buildup, involving and including any pins	$15
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post and core in addition to crown, indirectly fabricated	$20
	D2953		Each additional indirectly fabricated post - same tooth	$10
	D2954		Prefabricated post and core in addition to crown	$20
	D2955		Post removal (not in conjunction with endodontic therapy)	$0
	D2957		Each additional prefabricated post - same tooth	$10
	D2962		Labial veneer - porcelain laminate (laboratory)	$600
			Rebond Veneer	$80
	D2971		Additional procedures to construct new crown under existing partial denture framework	$25
	D2980		Crown repair, by report	$0
		@	Lumineer	$600
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$10
	D3221		Pulpal debridement, primary and permanent teeth	$10

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
ENDODONTIC THERAPY ON PRIMARY TEETH				
	D3230		Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$15
	D3240		Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$15
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$40
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$60
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$75
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$45
	D3347		Retreatment of previous root canal therapy - premolar	$60
	D3348		Retreatment of previous root canal therapy - molar	$95
Apexification/				
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$45
	D3421		Apicoectomy premolar (first root)	$45
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$45
	D3426		Apicoectomy (each additional root)	$20
	D3430		Retrograde filling - per root	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$45
	D3472		Surgical repair of root resorption-premolar	$45
	D3473		Surgical repair of root resorption-molar	$45
	D3501		Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$55
	D3502		Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$60
	D3503		Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$95
OTHER ENDODONTIC PROCEDURES				
	D3910		Surgical procedure for isolation of tooth with rubber dam	$0
	D3920		Hemisection (including any root removal), not including root canal therapy	$25
	D3950		Canal preparation and fitting of preformed dowel or post	$0
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$20
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$15
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$30
	D4241		Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	$20

ADA CODE			*ADA DESCRIPTION	EM8820
	D4245		Apically positioned flap	$40
	D4249		Clinical crown lengthening - hard tissue	$45
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$115
	D4261		Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	$20
	D4263		Bone replacement graft - first site in quadrant	$95
	D4264		Bone replacement graft - each additional site in quadrant	$75
	D4274		Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$30
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$15
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$5
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
	D4355		Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$15
	D4381		Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	$35
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal maintenance	$25
	D4921		Gingival Irrigation with a medicinal agent - Per quadrant	$20
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$120
	D5120		Complete denture - mandibular	$120
	D5130		Immediate denture - maxillary	$135
	D5140		Immediate denture - mandibular	$135
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$75
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$75
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$115
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$115
	D5221		Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$75
	D5222		Immediate mandibular partial denture- resin base (including any conventional clasps, rests and teeth)	$75
	D5223		Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$115
	D5224		Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps)	$115

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
	D5225		Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$115
	D5226		Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$115
	D5282		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -maxillary	$85
	D5283		Removable unilateral partial denture - one piece cast metal (including clasps and teeth) -mandibular	$85
	D5284		Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$85
	D5286		Removable unilateral partial denture - one piece resin (including clasps and teeth) per quadrant	$85
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$10
	D5411		Adjust complete denture - mandibular	$10
	D5421		Adjust partial denture - maxillary	$10
	D5422		Adjust partial denture - mandibular	$10
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$15
	D5512		Repair broker complete denture base, maxillary	$15
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$15
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$15
	D5612		Repair resin partial denture base, maxillary	$15
	D5621		Repair cast partial framework, mandibular	$15
	D5622		Repair cast partial framework, maxillary	$15
	D5630		Repair or replace broken clasp- per tooth	$15
	D5640		Replace broken teeth - per tooth	$15
	D5650		Add tooth to existing partial denture	$15
	D5660		Add clasp to existing partial denture - per tooth	$15
	D5670		Replace all teeth and acrylic on cast metal framework (maxillary)	$75
	D5671		Replace all teeth and acrylic on cast metal framework (mandibular)	$75
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$30
	D5711		Rebase complete mandibular denture	$30
	D5720		Rebase maxillary partial denture	$30
	D5721		Rebase mandibular partial denture	$30
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$15
	D5731		Reline complete mandibular denture (chairside)	$15
	D5740		Reline maxillary partial denture (chairside)	$15
	D5741		Reline mandibular partial denture (chairside)	$15
	D5750		Reline complete maxillary denture (laboratory)	$30
	D5751		Reline complete mandibular denture (laboratory)	$30

	ADA CODE		*ADA DESCRIPTION	EM8820
	D5760		Reline maxillary partial denture (laboratory)	$30
	D5761		Reline mandibular partial denture (laboratory)	$30
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5810		Interim complete denture (maxillary)	$150
	D5811		Interim complete denture (mandibular)	$150
	D5820		Interim partial denture (maxillary)	$60
	D5821		Interim partial denture (mandibular)	$60
	D5850		Tissue conditioning, maxillary	$20
	D5851		Tissue conditioning, mandibular	$20
MAXILLOFACIAL PROSTHETICS				
	D5995		Periodontal medicament carrier with peripheral seal - laboratory processed - maxillary	$200
	D5996		Periodontal medicament carrier with peripheral seal - laboratory processed - mandibular	$200
IMPLANT SERVICES				
	D6010	@	Surgical placement of implant body: endosteal implant	$1,690
	D6058	@	Abutment supported porcelain/ceramic crown	$960
	D6059	@	Abutment supported porcelain fused to metal crown (high noble metal)	$965
	D6060	@	Abutment supported porcelain fused to metal crown (predominantly base metal)	$915
	D6061	@	Abutment supported porcelain fused to metal crown (noble metal)	$930
	D6062	@	Abutment supported cast metal crown (high noble metal)	$925
	D6063	@	Abutment supported cast metal crown (predominantly base metal)	$800
	D6064	@	Abutment supported cast metal crown (noble metal)	$840
	D6065	@	Implant supported porcelain/ceramic crown	$955
	D6066	@	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$935
	D6067	@	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$910
	D6068	@	Abutment supported retainer for porcelain/ceramic FPD	$975
	D6069	@	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$965
	D6070	@	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$915
	D6071	@	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$930
	D6072	@	Abutment supported retainer for cast metal FPD (high noble metal)	$950
	D6073	@	Abutment supported retainer for cast metal FPD (predominantly base metal)	$860
	D6074	@	Abutment supported retainer for cast metal FPD (noble metal)	$925
	D6081		Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$5
	D6094	@	Abutment supported crown - (titanium)	$600
	D6191		Semi-precision abutment - placement	$600
	D6192		Semi-precision attachment - placement	$600

	ADA CODE		*ADA DESCRIPTION	EM8820
	D6194	@	Abutment supported retainer crown for FPD (titanium)	$500
	D6195	@	Abutment supported retainer - porcelain fused to titanium or titanium alloy	$90
FIXED PARTIAL DENTURE PONTICS				
	D6205		Pontic - indirect resin based composite not to be used as a temporary or provisional prosthesis	$100
	D6210	◆	Pontic - cast high noble metal	$90
	D6211		Pontic - cast predominantly base metal	$90
	D6212	◆	Pontic - cast noble metal	$90
	D6214	◆	Pontic - titanium	$90
	D6240	◆	Pontic - porcelain fused to high noble metal	$90
	D6241		Pontic - porcelain fused to predominantly base metal	$90
	D6242	◆	Pontic - porcelain fused to noble metal	$90
	D6243	◆	Pontic - porcelain fused to titanium or titanium alloys	$90
	D6245		Pontic - porcelain/ceramic	$100
	D6250	◆	Pontic - resin with high noble metal	$90
	D6251		Pontic - resin with predominantly base metal	$90
	D6252	◆	Pontic - resin with noble metal	$90
FIXED PARTIAL DENTURE RETAINTERS - INLAYS/ONLAYS				
	D6545		Retainer - cast metal for resin bonded fixed prosthesis	$70
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6710		Crown - indirect resin based composite	$100
	D6720	◆	Crown - resin with high noble metal	$90
	D6721		Crown - resin with predominantly base metal	$90
	D6722	◆	Crown - resin with noble metal	$100
	D6740		Crown - porcelain/ceramic	$100
	D6750	◆	Crown - porcelain fused to high noble metal	$90
	D6751		Crown - porcelain fused to predominantly base metal	$90
	D6752	◆	Crown - porcelain fused to noble metal	$90
	D6753	◆	Retainer crown - porcelain fused to titanium or titanium alloys	$90
	D6780	◆	Crown - 3/4 cast high noble metal	$90
	D6781		Crown - 3/4 cast predominantly base metal	$90
	D6782	◆	Crown - 3/4 cast noble metal	$90
	D6783		Crown - 3/4 cast porcelain/ceramic	$100
	D6784	◆	Retainer crown 3/4 - titaninium and titanium alloys	$90
	D6790	◆	Crown - full cast high noble metal	$90
	D6791		Crown - full cast predominantly base metal	$90
	D6792	◆	Crown - full cast noble metal	$90
	D6794	◆	Crown - titanium	$90
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
	D6940		Stress breaker	$85
	D6980		Fixed partial denture repair, by report	$0

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$15
	D7140		Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$20
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$15
	D7220		Removal of impacted tooth - soft tissue	$40
	D7230		Removal of impacted tooth - partially bony	$45
	D7240		Removal of impacted tooth - completely bony	$70
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$70
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$70
OTHER SURGICAL				
	D7270		Tooth reimplantation and/or stabilization of accidentally evulsed	$190
	D7280		Surgical access of an unerupted tooth	$15
	D7283		Placement of device to facilitate eruption of impacted tooth	$5
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$40
	D7286		Biopsy of oral tissue - soft (all others)	$40
	D7288		Brush biopsy - transepithelial sample collection	$40
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$15
	D7311		Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$10
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$15
	D7321		Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$10
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$40
EXCISION OF BONE TISSUE				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$225
	D7485		Surgical reduction of osseous tuberosity	$225
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$15
	D7520		Incision and drainage of abscess - extraoral soft tissue	$25
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0
	D7961		buccal/labial frenectomy	$20
	D7962		lingual frenectomy	$20
	D7963		Frenuloplasty	$15
	D7970		Excision of hyperplastic tissue - per arch	$30

Schedule of Benefits

ADA CODE			*ADA DESCRIPTION	EM8820
	D7971		Excision of pericoronal gingiva	$15
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8010		Limited orthodontic treatment of the primary dentition	$800
	D8020		Limited orthodontic treatment of the transitional dentition	$800
	D8030		Limited orthodontic treatment of the adolescent dentition	$800
	D8040		Limited orthodontic treatment of the adult dentition	$800
	D8050		Interceptive orthodontic treatment of the primary dentition	$950
	D8060		Interceptive orthodontic treatment of the transitional dentition	$950
	D8070		Comprehensive orthodontic treatment of the transitional dentition	$1,600
	D8080		Comprehensive orthodontic treatment of the adolescent dentition	$1,600
	D8090		Comprehensive orthodontic treatment of the adult dentition	$2,100
OTHER ORTHODONTIC SERVICES				
	D8660		Pre-orthodontic treatment visit	$0
	D8680		Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$250
	D8999		Orthodontic records fee	$275
UNCLASSIFIED TREATMENT				
	D9110		Palliative treatment of dental pain - per visit	$10
ANESTHESIA				
	D9210		Local anesthesia not in conjunction with operative or surgical procedures	$0
	D9211		Regional block anesthesia	$0
	D9212		Trigeminal division block anesthesia	$0
	D9215		Local anesthesia	$0
	D9222		Deep sedation/general anesthesia - first 15 minutes	$150
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$150
	D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$30
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$135
	D9243		Intravenous conscious sedation/analgesia - 15 minute increment	$135
PROFESSIONAL CONSULTATION				
	D9310		Consultation - (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
PROFESSIONAL VISITS				
	D9430		Office visit for observation (during regularly scheduled hours) - no other services performed	$0
	D9440		Office visit, after regularly scheduled hours	$30
MISCELLANEOUS SERVICES				
	D9910		Application of desensitizing medicament	$20
	D9932		Cleaning and inspection of removable complete denture, maxilla	$0
	D9933		Cleaning and inspection of removable complete denture, mandib	$0
	D9934		Cleaning and inspection of removable partial denture maxillary	$0
	D9935		Cleaning and inspection of removable partial denture, mandibula	$0

ADA CODE			*ADA DESCRIPTION	EM8820
	D9944		Occlusal guard - hard appliance, full arch	$150
	D9945		Occlusal guard - soft appliance, full arch	$150
	D9946		Occlusal guard - hard appliance, partial arch	$150
	D9951		Occlusal adjustment - limited	$10
	D9952		Occlusal adjustment - complete	$30
NON CLINICAL PROCEDURES				
	D9986		Missed appointment	$0
	D9987		Cancelled appointment	$0
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9997		Dental case management - patients with special health care needs	$0

FOOTNOTES

◆ **Metal charges apply to a maximum of $125**

@ **Where available**

CDT 2024

EM8820 Provider Minimum Guarantee

ADA	Description	Minimum Guarantee
D0210	intraoral - complete series of radiographic images	$ 10.00
D0330	Panographic radiographic image	$ 10.00
D1110	Prophylaxis - adult	$ 20.00
D1120	Prophylaxis - child	$ 15.00
D1351	Sealant - per tooth	$ 10.00
D2140	Amalgam - one surface, primary or permanent	$ 5.00
D2150	Amalgam - two surfaces, primary or permanent	$ 10.00
D2160	Amalgam - three surfaces, primary or permanent	$ 10.00
D2161	Amalgam - four or more surfaces, primary or permanent	$ 15.00
D2330	Resin-based composite - one surface, anterior	$ 10.00
D2331	Resin-based composite - two surfaces, anterior	$ 15.00
D2332	Resin-based composite - three surfaces, anterior	$ 15.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$ 20.00
D2390	Resin - Composite Crown (Anterior)	$ 20.00
D2391	Resin - 1 Surf. (Posterior)	$ 55.00
D2392	Resin - 2 Surf. (Posterior)	$ 65.00
D2393	Resin - 3 Surf. (Posterior)	$ 75.00
D2394	Resin - 4 + Surf. (Posterior)	$ 85.00
D2510	Inlay - Metallic - One Surface	$ 190.00
D2520	Inlay - Metallic - Two Surfaces	$ 200.00
D2530	Inlay - Metallic - Three or more Surfaces	$ 200.00
D2542	Onlay - Metallic - Two surfaces	$ 210.00
D2543	Onlay - Metallic - Three surfaces	$ 210.00
D2544	Onlay - Metallic - Four or more surfaces	$ 210.00
D2710	Crown - resin - based compisite (indirect)	$ 120.00
D2712	Crown - 3/4 resin - base composite (indirect)	$ 120.00
D2720	Crown - Resin high noble metal	$ 335.00
D2721	Crown - Resin base metal	$ 210.00
D2722	Crown - Resin noble metal	$ 300.00
D2740	crown - porcelain/ceramic substrate	$ 195.00
D2750	Crown - porcelain fused to high noble metal	$ 335.00
D2751	Crown - porcelain fused to predominantly base metal	$ 210.00
D2752	Crown - porcelain fused to noble metal	$ 335.00
D2780	Crown - 3/4 cast high noble metal	$ 335.00
D2781	Crown - 3/4 cast predominantly base metal	$ 210.00
D2782	Crown - 3/4 cast noble metal	$ 335.00
D2783	Crown - 3/4 porcelain/ceramic	$ 200.00
D2790	Crown - full cast high noble metal	$ 335.00
D2791	Crown - full cast predominantly base metal	$ 115.00

EM8820 Provider Minimum Guarantee

D2792	Crown - full cast noble metal	$	240.00
D2794	Crown - titanium and titanium alloys	$	240.00
D2799	Provisional crown - further tx or completion of diag. necessary prior final imp.	$	10.00
D2930	Prefabricated stainless steel crown - primary tooth	$	10.00
D2931	Prefabricated stainless steel crown - permanent tooth	$	10.00
D2932	Prefabricated resin crown	$	10.00
D2933	Prefabricated stainless steel crown with resin window	$	10.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$	10.00
D2952	Post and core in addition to crown indirectly fabricated	$	50.00
D2954	Prefabricated post and core in addition to crown	$	50.00
D2971	Additional procedures to construct new crown under existing partial denture frame	$	30.00
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$	40.00
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$	80.00
D3330	endodontic therapy, molar (excluding final restoration)	$	250.00
D3346	Retreatment of previous root canal therapy - anterior	$	40.00
D3347	Retreatment of previous root canal therapy - premolar	$	80.00
D3348	Retreatment of previous root canal therapy - molar	$	250.00
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$	15.00
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$	5.00
D4355	Full mouth debridement to enable a comprehensice oral evaluation and diagnosis on a subsequent visit	$	20.00
D5110	complete denture - maxillary	$	330.00
D5120	complete denture - mandibular	$	330.00
D5130	immediate denture - maxillary	$	355.00
D5140	immediate denture - mandibular	$	355.00
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$	250.00
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$	250.00
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$	360.00
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$	360.00
D5225	Maxillary partial denture - flexible base (including any clasps rests and teeth)	$	360.00
D5226	Mandibular partial denture - flexible base (including any clasps rests and teeth)	$	360.00
D5710	Rebase complete maxillary denture	$	80.00
D5711	Rebase complete mandubular denture	$	80.00
D5720	Rebase maxillary partial denture	$	70.00
D5721	Rebase mandibular partial denture	$	70.00
D5750	Reline complete maxillary denture (laboratory)	$	80.00
D5751	Reline complete mandibular denture (laboratory)	$	80.00
D5760	Reline maxillary partial denture (laboratory)	$	70.00
D5761	Reline mandibular partial denture (laboratory)	$	70.00

EM8820 Provider Minimum Guarantee

D6205	Pontic - indirect resin based composite	$	195.00
D6210	Pontic - cast high noble metal	$	295.00
D6211	Pontic - cast predominantly base metal	$	175.00
D6212	Pontic - cast noble metal	$	295.00
D6214	Pontic - Titanium	$	175.00
D6240	Pontic - Porcelain fused to high noble metal	$	295.00
D6241	Pontic - Porcelain fused to predominantly base metal	$	170.00
D6242	Pontic - Porcelain fused to noble metal	$	295.00
D6245	Pontic - Porcelain/ ceramic	$	195.00
D6250	Pontic - Resin high noble metal	$	295.00
D6251	Pontic - Resin base metal	$	295.00
D6252	Pontic - Resin noble metal	$	295.00
D6710	Retainer crown - indirect resin based composite	$	195.00
D6720	Abutment - Resin high noble metal	$	335.00
D6721	Abutment - Resin base metal	$	210.00
D6722	Abutment - Resin noble metal	$	335.00
D6740	Retainer crown - porcelain/ ceramic	$	205.00
D6750	Retainer crown - porcelain fused to high noble metal	$	335.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$	205.00
D6752	Retainer crown - porcelain fused to noble metal	$	335.00
D6780	Retainer crown - 3/4 cast high noble metal	$	335.00
D6781	Retainer crown - 3/4 cast perdominantly base metal	$	205.00
D6782	Retainer crown - 3/4 cast noble metal	$	335.00
D6783	Retainer crown - 3/4 porcelain/ ceramic	$	205.00
D6790	Retainer crown - full cast high noble metal	$	335.00
D6791	Retainer crown - full cast predominantly base metal	$	205.00
D6792	Retainer crown - full cast noble metal	$	335.00
D6794	Crown - Titanium	$	240.00
D6972	Prefab post and core - In add to FPD Retainer	$	50.00
D7210	Extraction erupted tooth req removal of bone and/ or sectioning of tooth incl. elevt.	$	20.00
D7220	Removal of impacted tooth - soft tissue	$	35.00
D7230	Removal of impacted tooth - partially bony	$	40.00
D7240	Removal of impacted tooth - completely bony	$	45.00
D7250	Removal of residual tooth roots (cutting procedure)	$	45.00

LIMITATIONS & EXCLUSIONS

LIMITATIONS

The following Limitations apply to Services Covered in the Schedule of Benefits:

Diagnostic

Full Mouth X-Ray, Panoramic Film, Cephalometric Film, and Oral/Facial
Images- once in a two-year period.

Coverage for bitewing X-rays - no more than one series of four (4) films in any six-month period.

Preventive

Prophylaxis covered twice in twelve (12) months. Examples of situations where an additional prophylaxis within the twelve (12) month period may be necessary for the dental health of the Member and may be covered subject to the determination of the treating provider are:

1) Pregnancy,
2) Pre-radiation therapy as ordered by an oncologist,
3) Gingival hyperplasia due to the use of Dilantin or other medications,
4) Inflammation due to syphilis or tuberculosis,
5) Chronic menopausal gingivostomatitis,
6) Leukemia or HIV induced gingivitis.

Fluoride Treatments (Topical Application and Fluoride Varnish).

Topical Fluoride Treatments are limited to two (2) treatments in a 12 consecutive month period.

Restorative Services

Crowns, Inlays and Onlays

Will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that the tooth cannot hold a filling).

Use of precious metal in fabrication of a crown, inlay or onlay is considered elective and an additional metal charge will apply.

Endodontics

Endodontic Re-treatments (ADA Codes D3346, D3347 and D3348) are limited to one (1) per tooth per lifetime.

Apicoectomies (ADA Codes D3410, D3421, D3425 and D3426) are limited to one (1) per root per lifetime.

Periodontics

Scaling and Root Planing (per quadrant) and Full Mouth Debridement are covered once every twelve (12) months.

Crown lengthening (ADA Code D4249) is limited to one (1) per tooth per lifetime.

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old and cannot be made serviceable by reline, rebase or repair.

Tooth Additions and Repair to Existing Denture, Repair of appliances damaged due to Member abuse, Denture Reline and Rebase and Relines of full or partial dentures are limited to twice in a calendar year.

Fixed Bridge(s), Pontics, and Crowns

Replacement of an existing appliance will be covered if the appliance is over five years old, is defective and cannot be made serviceable.

Fixed bridges are a covered benefit when a removable partial denture cannot satisfactorily restore the arch in accordance with professionally recognized standards of dental practice.

If the Member elects a fixed bridge instead of the covered removable partial denture, the Member's benefit for the partial denture will be applied to the Member's cost for the fixed bridge as follows:

Copayment for the fixed bridge = UCR Cost of the Fixed Bridge – UCR Cost of the Removable Partial Denture + the Copayment of the Removable Partial Denture.

If the Member has unreplaced missing teeth on opposite sides of the same arch, a removable partial denture is considered the covered benefit.

The Plan provides coverage for up to six units for crown and/or fixed bridges in the same treatment plan.

Each tooth treated with a crown and replaced tooth in a fixed bridge ("pontic") included in the treatment plan is referred to as a "unit". When a treatment plan consists of more than six units of crowns and/or bridges, the term "full mouth reconstruction" is used to describe the treatment plan, and units in excess of six are not a Covered Service, and the Member will be charged at the Participating Provider's usual and customary rate.

Pediatric Dentistry Referrals

Referral for pediatric dentistry services for children under the age of six years must be pre-authorized by the Plan. Exceptions for physical or mental handicaps or medically compromised individuals, when confirmed by the treating physician, may be considered on an individual basis with prior approval from the Plan

Limitations apply unless the treating Participating Provider can document that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice, at which point such services will be covered as set forth in the accompanying Schedule of Benefits.

LIMITATIONS & EXCLUSIONS

ORTHODONTIC COVERAGES

The Plan's orthodontic benefit covers only basic orthodontic treatment to resolve malocclusion and establish optimal dental and facial esthetics. Orthodontic treatment may involve the primary, transitional or permanent dentition. All orthodontic services must be provided by a Participating Provider to be covered under the Benefit Plan. Refer to the "Orthodontics" category of your Schedule of Benefits to determine which specific procedures are Covered Services and their Copayment amounts.

ORTHODONTIC LIMITATIONS

Benefits for any phase of Orthodontic treatment are limited to a maximum of 24 months. Treatment extending beyond the 24th month may be charged a monthly continuation fee per the Member's Orthodontic contract with the provider.

ORTHODONTIC EXCLUSIONS

The following dental procedures and services are excluded from this coverage:

Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders).

TMJ/Myofunctional Therapy – Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture.

Surgical Orthodontics – Orthodontic treatment in conjunction with Orthognathic surgery.

Orthognathic Surgery – Surgery to move the jaw bones into alignment.

Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth.

Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth.

Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage.

Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan.

Retreatment of Orthodontic Cases – The treatment of orthodontic problems that have been treated before.

Repair or replacement of lost, stolen, damaged or broken appliances, including retainers, brackets, bands, wires or other materials supplied by the orthodontist.

Extractions for Orthodontic Purposes – Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

Post-treatment Records - X-rays, photographs and models following orthodontic treatment.

LIMITATIONS & EXCLUSIONS

EXCLUSIONS

The following dental procedures and services are excluded from this coverage by the Benefit Plan:

Preventive

Supplies used for oral hygiene, plaque control, oral physiotherapy instruction, and chemical analysis of saliva.

Restorative Services

Crowns, Inlays and Onlays

Crowns, inlays or onlays that are only for cosmetic purposes.

Crowns, inlays or onlays that are lost, stolen, or damaged due to Member abuse, misuse or neglect.

Crowns and pontics supported on a dental implant.

Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances.

Periodontics

Soft Tissue Grafts.

Complete and Partial Dentures

Replacement or repair of a lost, stolen, or damaged appliance due to Member abuse.

Removable Prosthetic Services and supplies that are only for cosmetic purposes.

Implant supported dentures, unless specifically listed as a covered benefit under your plan.

Fixed Bridges

Replacement or repair of a lost, stolen, or damaged bridge due to Member abuse.

Distal extension posterior cantilever pontics, which are supported at the front end only.

Implant supported bridges, unless specifically listed as a covered benefit under your plan.

Oral Surgery

Removal of third molars (wisdom teeth), supernumerary teeth or other teeth that are impacted that do not have associated pathology.

Removal of teeth for orthodontic purposes only.

General Exclusions

Treatment by someone other than a Participating Provider or dental auxiliary under the direction of a Participating Provider, except for Emergency treatment as provided in the EOC (Evidence of Coverage) or upon prior authorization by the Plan.

Charges for medical treatment, prescriptions or other charges not directly related to dental services provided.
Hospitalization costs for any dental procedure, including all hospital services, anesthesia and medications.

Any dental treatment that is determined by the Plan to be the responsibility of Worker's Compensation, employer, the health care plan, payable under any Federal Government or state program, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy, or for services for which benefits are payable under any other insurance.

Treatment of malignancies, neoplasms, and cysts, unless specifically listed as a Covered Service on the Schedule of Benefits.

Treatment of Myofacial pain or disturbances of the Temporomandibular Joint (TMJ), including correction of occlusion or "occlusal equilibration".

Procedures, restorations, and appliances to correct congenital or developmental malformations.

Services and supplies that are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice.

Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage or dental expenses incurred in connection with any dental procedure started after termination of coverage.

Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion, including, but not limited to, full mouth rehabilitation, splinting, appliances or any other method.

Appliances to correct and control harmful habits (e.g. tongue thrust and thumb sucking).

San Diego County Teamsters

Schedule of Benefits

WD PLAN GROUP AND INDIVIDUAL

MIB Benefit Plans

SD TEAMSTERS

ADA CODE	*ADA DESCRIPTION	
CLINICAL ORAL EVALUATIONS		
D0120	Periodic oral examination - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
D0171	Re-evaluation - post operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)		
D0210	Intraoral comprehensive series of radiographic images	$0
D0220	Intraoral - periapical radiographic image	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal radiographic	$0
D0250	Extra-oral single film	$0
D0260	Extraoral - each additional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings - three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings - 7 to 8 films	$0
D0330	Panoramic film	$0
TESTS AND EXAMINATIONS		
D0419	Assement of salivary flow by measurement	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0701	Panoramic radiographic image- image capture only	$0
D0702	2-D cephalometric radiographic- image capture only	$0
D0703	2-D oral/facial photographic image obtianed intra-orally or extra-orally - image capture only	$0
D0705	extra-oral posterior dental radiographic image capture only	$0
D0706	intraoral- occlusal radiographic image- image capture only	$0
D0707	intraoral- periapical radiographic image- image capture only	$0
D0708	intraoral- bitewing radiographic image- image capture only	$0
D0709	intraoral- complete series of radiographic images- image capture only	$0
ORAL PATHOLOGY LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other)	$0
DENTAL PROPHYLAXIS		
D1110	Prophylaxis - adult	$0
D1120	Prophylaxis - child	$0

	ADA CODE		*ADA DESCRIPTION	
TOPICAL FLUORIDE TREATMENT (office procedure)				
	D1206		Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$0
	D1208		Topical application of fluoride- excluding varnish - child to age 19 *limited to 2 per 12 month period*	$0
OTHER PREVENTIVE SERVICES				
	D1310		Nutritional Counseling for control of dental disease	$0
	D1320		Tobacco counseling for the control and prevention of oral diseas	$0
	D1330		Oral hygiene instructions	$0
	D1351		Sealant - per tooth	$8
	D1352		Preventative resin restoration in a moderate to high caries risk patient - permanent tooth.	$0
	D1353		Sealant repair - per tooth - limited to permanent molars through age 15	$0
	D1354		Interim caries arresting medicament application - per tooth	$0
SPACE MAINTENANCE (passive appliances)				
	D1510		Space maintainer - fixed - unilateral (excludes a distal shoe space maintainer)	$0
	D1516		Space maintainer - fixed - bilateral - maxillary	$0
	D1517		Space maintainer - fixed - bilateral - mandibular	$0
	D1520		Space maintainer - removable - unilateral	$0
	D1526		Space maintainer - removable - maxillary	$0
	D1527		Space maintainer - removable - mandibular	$0
	D1551		Re-cement or re-bond bilateral space maintainer	$0
	D1552		Re-cement or re-bond unilateral space maintainer	$0
	D1553		Re-cement or re-bond unilateral space maintainer - per quadrant	$0
	D1556		Removal of fixed unilateral space maintainer - per quadrant	$0
	D1557		Removal of fixed bilateral space maintainer maxillary	$0
	D1558		Removal of fixed bilateral space maintainer mandibular	$0
	D1575		Distal shoe space maintainer - fixed unilateral	$0
AMALGAM RESTORATIONS (including polishing)				
	D2140		Amalgam - one surface, primary or permanent	$0
	D2150		Amalgam - two surfaces, primary or permanent	$0
	D2160		Amalgam - three surfaces, primary or permanent	$0
	D2161		Amalgam - four or more surfaces, primary or permanent	$0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT				
	D2330		Resin-based composite - one surface, anterior	$0
	D2331		Resin-based composite - two surfaces, anterior	$0
	D2332		Resin-based composite - three surfaces, anterior	$0
	D2335		Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$0
	D2390		Resin-based composite crown, anterior	$0
CROWNS - SINGLE RESTORATIONS ONLY				
	D2750		Crown - porcelain fused to high noble metal	$55
	D2751		Crown - porcelain fused to predominantly base metal	$55
	D2752		Crown - porcelain fused to noble metal	$55
	D2753		Crown- porcelain fused to titanium or titanium alloy	$55
	D2790		Crown - full cast high noble metal	$40
	D2791		Crown - full cast predominantly base metal	$40
OTHER RESTORATIVE SERVICES				
	D2910		Recement inlay, onlay, or partial coverage restoration	$0
	D2920		Recement crown	$0
	D2930		Prefabricated stainless steel crown - primary tooth	$0

ADA CODE			*ADA DESCRIPTION	
	D2940		Sedative filling	$0
	D2950		Core buildup, involving and including any pins	$0
	D2951		Pin retention - per tooth, in addition to restoration	$0
	D2952		Post and core in addition to crown, indirectly fabricated	$0
	D2954		Prefabricated post and core in addition to crown	$0
	D2955		Post removal (not in conjunction with endodontic therapy)	$0
PULP CAPPING				
	D3110		Pulp cap - direct (excluding final restoration)	$0
	D3120		Pulp cap - indirect (excluding final restoration)	$0
PULPOTOMY				
	D3220		Therapeutic pulpotomy (excluding final restoration)	$0
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
	D3310		Anterior (excluding final restoration)	$0
	D3320		Endodontic therapy, premolar tooth (excluding final restoration)	$0
	D3330		Endodontic therapy, molar tooth (excluding final restoration)	$0
ENDODONTIC RETREATMENT				
	D3346		Retreatment of previous root canal therapy - anterior	$0
	D3347		Retreatment of previous root canal therapy - premolar	$0
	D3348		Retreatment of previous root canal therapy - molar	$0
Apexification/ Recalcifica				
APICOECTOMY/PERIRADICULAR SERVICES				
	D3410		Apicoectomy- anterior	$0
	D3421		Apicoectomy premolar (first root)	$0
	D3425		Apicoectomy/periradicular surgery - molar (first root)	$0
	D3426		Apicoectomy (each additional root)	$0
	D3450		Root amputation - per root	$0
	D3471		Surgical repair of root resorption-anterior	$0
	D3472		Surgical repair of root resorption-premolar	$0
	D3473		Surgical repair of root resorption-molar	$0
SURGICAL SERVICES (including usual postoperative care)				
	D4210		Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$0
	D4211		Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	$5
	D4240		Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$25
	D4260		Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$40
	D4263		Bone replacement graft - first site in quadrant	$0
	D4264		Bone replacement graft - each additional site in quadrant	$0
NON-SURGICAL PERIODONTAL SERVICES				
	D4341		Periodontal scaling and root planing - four or more teeth per quadrant	$0
	D4342		Periodontal scaling and root planing - one to three teeth per quadrant	$0
	D4346		Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$0
OTHER PERIODONTAL SERVICES				
	D4910		Periodontal maintenance	$0
COMPLETE DENTURES (including routine post-delivery care)				
	D5110		Complete denture - maxillary	$75

	ADA CODE		*ADA DESCRIPTION	
	D5120		Complete denture - mandibular	$75
	D5130		Immediate denture - maxillary	$75
	D5140		Immediate denture - mandibular	$75
PARTIAL DENTURES (including routine post-delivery care)				
	D5211		Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$75
	D5212		Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$75
	D5213		Maxillary partial denture - cast metal framework with resin denture bases (incuding. any conventional clasps, rests and teeth)	$75
	D5214		Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$75
ADJUSTMENTS TO DENTURES				
	D5410		Adjust complete denture - maxillary	$0
	D5411		Adjust complete denture - mandibular	$0
	D5421		Adjust partial denture - maxillary	$0
	D5422		Adjust partial denture - mandibular	$0
REPAIRS TO COMPLETE DENTURES				
	D5511		Repair broken complete denture base, mandibular	$0
	D5512		Repair broker complete denture base, maxillary	$0
	D5520		Replace missing or broken teeth - complete denture (each tooth)	$0
REPAIRS TO PARTIAL DENTURES				
	D5611		Repair resin partial denture base, mandibular	$0
	D5612		Repair resin partial denture base, maxillary	$0
	D5621		Repair cast partial framework, mandibular	$0
	D5622		Repair cast partial framework, maxillary	$0
	D5630		Repair or replace broken clasp- per tooth	$0
	D5640		Replace broken teeth - per tooth	$0
	D5642		Replace missing/broke tooth each additional	$0
	D5650		Add tooth to existing partial denture	$0
	D5660		Add clasp to existing partial denture - per tooth	$0
DENTURE REBASE PROCEDURES				
	D5710		Rebase complete maxillary denture	$0
	D5711		Rebase complete mandibular denture	$0
	D5720		Rebase maxillary partial denture	$0
	D5721		Rebase mandibular partial denture	$0
DENTURE RELINE PROCEDURES				
	D5730		Reline complete maxillary denture (chairside)	$0
	D5731		Reline complete mandibular denture (chairside)	$0
	D5740		Reline maxillary partial denture (chairside)	$0
	D5741		Reline mandibular partial denture (chairside)	$0
	D5750		Reline complete maxillary denture (laboratory)	$0
	D5751		Reline complete mandibular denture (laboratory)	$0
	D5760		Reline maxillary partial denture (laboratory)	$0
	D5761		Reline mandibular partial denture (laboratory)	$0
OTHER REMOVABLE PROSTHETIC SERVICES				
	D5820		Interim partial denture (maxillary)	$0
	D5821		Interim partial denture (mandibular)	$0
	D5850		Tissue conditioning, maxillary	$0
	D5851		Tissue conditioning, mandibular	$0

ADA CODE			*ADA DESCRIPTION	
FIXED PARTIAL DENTURE PONTICS				
	D6210		Pontic - cast high noble metal	$40
	D6211		Pontic - cast predominantly base metal	$40
	D6212		Pontic - cast noble metal	$40
	D6240		Pontic - porcelain fused to high noble metal	$55
	D6241		Pontic - porcelain fused to predominantly base metal	$55
	D6242		Pontic - porcelain fused to noble metal	$55
	D6243		Pontic - porcelain fused to titanium or titanium alloys	$55
FIXED PARTIAL DENTURE RETAINERS - CROWNS				
	D6750		Crown - porcelain fused to high noble metal	$55
	D6751		Crown - porcelain fused to predominantly base metal	$55
	D6752		Crown - porcelain fused to noble metal	$55
	D6753		Retainer crown - porcelain fused to titanium or titanium alloys	$55
	D6780		Crown - 3/4 cast high noble metal	$40
	D6781		Crown - 3/4 cast predominantly base metal	$40
	D6782		Crown - 3/4 cast noble metal	$40
	D6783		Crown - 3/4 cast porcelain/ceramic	$40
	D6784		Retainer crown 3/4 - titaninium and titanium alloys	$55
	D6790		Crown - full cast high noble metal	$40
	D6791		Crown - full cast predominantly base metal	$40
	D6792		Crown - full cast noble metal	$40
OTHER FIXED PARTIAL DENTURE SERVICES				
	D6930		Recement fixed partial denture	$0
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7111		Extraction, coronal remnants - primary tooth	$0
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)				
	D7210		Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$0
	D7220		Removal of impacted tooth - soft tissue	$0
	D7230		Removal of impacted tooth - partially bony	$0
	D7240		Removal of impacted tooth - completely bony	$0
	D7241		Removal of impacted tooth - completely bony, with unusual surgical complications	$0
	D7250		Surgical removal of residual tooth roots (cutting procedure)	$0
OTHER SURGICAL PROCEDURES				
	D7280		Surgical access of an unerupted tooth	$0
	D7281		Surgical exposure of impacted or unerupted tooth to aid eruption	$0
	D7285		Biopsy of oral tissue - hard (bone, tooth)	$0
	D7286		Biopsy of oral tissue - soft (all others)	$0
ALVEOLOPLASTY (surgical preparation of ridge for dentures)				
	D7310		Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
	D7320		Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$0
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
	D7440		Excision of malignant tumor - lesion diameter up to 1.25 cm	$0
	D7441		Excision of malignant tumor - lesion diameter greater than 1.25	$0
	D7450		Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm	$0
	D7451		Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm	$0
	D7460		Removal Benign nonodontogenic cyst/tumor up to 1.25 cm	$0
	D7461		Removal benign nonodontogenic cyst/tumor 1.25 cm	$0

Schedule of Benefits

SD
TEAMSTERS

ADA CODE			*ADA DESCRIPTION	
EXCISION OF BONE TISSUE				
	D7471		Removal of lateral exostosis (maxilla or mandible)	$0
SURGICAL INCISION				
	D7510		Incision and drainage of abscess - intraoral soft tissue	$0
	D7511		Incision drainage abscess intraoral soft tissue complicated	$0
	D7560		Maxillary sinusotomy for removal of tooth fragment or foreign body	$0
OTHER REPAIR PROCEDURES				
	D7922		Placement of intra - socket biological dressing to aid in hemostasis or clot stabilization or clot stabilization, per site	$0
	D7961		Buccal/labial frenectomy	$0
	D7962		Lingual frenectomy	$0
COMPREHENSIVE ORTHODONTIC TREATMENT				
	D8210		Removable appliance therapy	$0
UNCLASSIFIED TREATMENT				
	D9110		Palliative treatment of dental pain - per visit	$0
ANESTHESIA				
	D9211		Regional block anesthesia	$0
	D9212		Trigeminal division block anesthesia	$0
	D9215		Local anesthesia	$0
	D9223		Deep sedation/general anesthesia - each 15 minute increment	$140
	D9230		Analgesia, anxiolysis, inhalation of nitrous oxide	$12
	D9239		Intravenous conscious sedation/analgesia - first 15 minutes	$49
PROFESSIONAL CONSULTATION				
	D9310		Consultation **-** (diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
PROFESSIONAL VISITS				
	D9440		Office visit, after regularly scheduled hours	$15
MISCELLANEOUS SERVICES				
	D9930		Post-operative visit - complications (osteitis)	$0
	D9944		Occlusal guard - hard appliance, full arch	$0
	D9945		Occlusal guard - soft appliance, full arch	$0
	D9946		Occlusal guard - hard appliance, partial arch	$0
	D9951		Occlusal adjustment - limited	$15
NON CLINICAL PROCEDURES				
	D9990		Certified Translation or Sign Language Services - per visit	$0
	D9997		Dental case management - patients with special health care needs	$0
			Broken appointment (per 15 mins. scheduled time)	5
			Orthodontics - Child (to age 23)	1450
			Orthodontics - Adult (age 23 and over) doe not include start-up fees or retention	1950

CDT 2024

San Diego County Teamsters Employers Insurance Trust

IX. LIMITATIONS

The following Limitations apply to Covered Services set out in the Benefits Section of this Evidence of Coverage Booklet. Where the description of a Limitation refers you to the Schedule of Benefits for more information or detail, refer to the corresponding category heading in the Schedule of Benefits.

A. DIAGNOSTIC – The following limitations apply to this category of services:

Full Mouth X-Ray/Bite Wing X-Ray

1. Coverage for full-mouth X-ray is limited to once in a two-year period.

2. Coverage for bite wing X-rays is limited to no more than one series of four in any six-month period, unless the Participating Provider determines additional X-rays are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

B. PREVENTIVE – The following Limitations apply to this category of services:

Prophylaxis

The Plan provides coverage for these "teeth cleanings" only once every six (6) months. If applicable, the Copayment for each cleaning is specified in the Schedule of Benefits. An additional prophylactic cleaning will be covered if the treating Participating Provider deems it necessary for the dental health of the Member, consistent with professionally recognized standards of dental practice. Some examples of situations where additional prophylaxes may be necessary for the dental health of the Member are:

1. Pre-radiation therapy as ordered by an oncologist;

2. Gingival hyperplasia due to the use of Dilantin for the treatment of epilepsy;

3. Inflammation due to syphilis or tuberculosis;

4. Chronic menopausal gingivostomatitis; and

5. Leukemia or HIV induced gingivitis.

Fluoride Treatments

1. Topical Fluoride is not a benefit for Members over the age of 18 years, unless the treating Participating Provider determines topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

2. Topical Fluoride Treatments are limited to one treatment in a 12 consecutive month period , unless the treating Participating Provider determines additional topical fluoride treatments are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

C. RESTORATIVE SERVICES – The following Limitations apply to this category of services:

Amalgam and Resin-Based Composite Restorations

Porcelain, composite or acrylic restorations posterior to the second bicuspid, unless specifically listed as a Covered Service of your Benefit Plan are considered purely cosmetic dentistry, and as such are not covered. (See attached Schedule of Benefit for detailed information). Members will be credited with an allowance for amalgam restorations toward such elective restorations. If performed, Member must pay the additional fee.

Crowns

1. Crowns will be covered when a filling cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental care (Example: buccal or lingual walls are either fractured or decayed to the extent that they do not hold a filling).

2. Replacement of an existing crown will be covered if the crown is over five years old or if the existing crown cannot adequately restore the dental health of a Member in accordance with professionally recognized standards of dental practice. The five-year limitation does not apply to clinically defective dentistry or to services rendered while the Member was not covered under this Benefit Plan.

3. Precious metal crowns – use of precious metal in fabrication of a crown is considered elective unless specifically listed as one of the Covered Services of your Plan. (See attached Schedule of Benefits for detailed information). If the Member elects to receive a precious metal crown that is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a full cast metal crown.

Other Restorative Services

Dowel Posts or Pins—These items are not covered except where insufficient coronal structure remains to retain the crown restoration.

D. PERIODONTICS – The following Limitations apply to this category of services:

Subgingival Scaling and Root Planing

This procedure is covered once every six months, unless necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

E. PROSTHODONTICS, REMOVABLE – The following Limitations apply to this category of services:

Complete and Partial Dentures

Replacement of an existing appliance will be covered if the appliance is over five years old. Replacement of appliances that are less than five years old is covered only if the appliance was originally provided while the Member was not covered under any Western Dental Benefit Plan, if replacement is required as a result of clinically defective dentistry, or when replacement is necessary for the dental health of the Member consistent with professionally recognized standards of dental practice and preauthorized by the Plan.

Tooth Additions and Repair to Existing Denture

Repair of appliances damaged due to Member abuse is not covered.

Denture Reline and Rebase

Relines of full or partial dentures are limited to twice per calendar year, unless the treating Participating Provider determines that additional relines are necessary for the dental health of the Member in accordance with professionally recognized standards of dental practice.

F. PROSTHODONTICS, FIXED (Fixed Partial Dentures or Bridges) – The following Limitations apply to this category of services:

Fixed Partial Dentures, Pontics, and Crowns

1. Replacement of an existing appliance will be covered if the appliance is over five years old. The five year limitation does not apply to services rendered while the Member was not covered, or to replacement required as a result of clinically defective dentistry.

2. Precious metal Fixed Partial Dentures are not covered unless specifically listed as a Covered Service of your Benefit Plan in the Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice. If the Member elects to receive a precious metal Fixed Partial Denture when it is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a non-precious metal Fixed Partial denture.

3. Stress Breaker (non-rigid connector between the abutment and the pontic) is not covered unless specifically listed as a Covered Service of your Benefit Plan in the Schedule of Benefits or the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

Fixed Partial Dentures Services

Posts are not covered except where insufficient coronal structure remains to retain the crown restoration.

G. ORAL SURGERY – The following Limitations apply to this category of services:

Extractions for orthodontic purposes are not covered if the tooth is not diseased.

H. ORTHODONTICS – The following services are not included in the Limited Orthodontic Treatment or Comprehensive Orthodontic Treatment Copayments, and they are not Covered Services unless specifically identified in the Schedule of Benefits.

1. Start-up Services – Including preparation of orthodontic records consisting of x-rays, cephalometric x-rays, tracings, and case study models, are not included in the Limited or Comprehensive Orthodontic Treatment Copayments. If the Member's Schedule of Benefits identifies a Start-up Services Copayment, the Member must pay the Copayment for Start-up Services. If there is no Start-up Services Copayment identified in the Member's Schedule of Benefits, Start-up Services are not covered under the Member's Benefit Plan, and the Member must pay the usual, customary and reasonable charges of the Participating Provider for Start-Up Services. (See attached Schedule of Benefits for detailed information.)

2. Retention-Retainers to hold and monitor the teeth following orthodontics (braces) are not included in the Limited or Comprehensive Orthodontic Treatment Copayments.

3. Services Required Because of Gross Non-Cooperation – Additional services required because Member's cooperation does not meet the minimum level necessary to complete the treatment adequately, or is damaging to the teeth, are not included in the Limited or Comprehensive Orthodontic Treatment Copayments.

   Should treatment extend beyond the original estimated treatment time due to Member's non-compliance, Member will be subject to an office visit Copayment for each additional office visit necessary until orthodontic care is completed. Each such office visit Copayment will equal the result obtained by dividing Member's total original Limited or Comprehensive Orthodontic Treatment Copayment, as set forth in the Schedule of Benefits, divided by the number of months in the original treatment plan.

4. Post-treatment Records – x-rays, photographs and models following orthodontic treatment are not included in the Limited or Comprehensive Orthodontic Treatment Copayments.

I. SPECIALIST REFERRALS – Prior authorization from the Plan is required for coverage of dental services provided by a Specialist. Please refer to the Specialist Referrals Section of this Evidence of Coverage Booklet. Referral to a participating Pedodontist Specialist for chil-

dren under the age of six years is available and must be pre-authorized by the Plan.

X. EXCLUSIONS

The following dental procedures and services are not covered by the Benefit Plan. No dental service is covered unless specifically identified in the Schedule of Benefits. Where the description of an Exclusion refers you to the Schedule of Benefits for more information or detail, refer to the corresponding category heading in the Schedule of Benefits.

A. Preventive

Supplies used for oral hygiene, plaque control, oral psychotherapy instruction, and chemical analysis of saliva.

B. Restorative Services

1. Crowns that are cosmetic in nature are not covered.

2. Crowns that are lost, stolen, or damaged when due to Member abuse, misuse or neglect.

3. Implant supported crown and abutment supported crowns on a dental implant are not a Covered Service.

4. Porcelain, composite or acrylic crown restorations posterior to the second bicuspid, unless specifically listed as one of the Covered Services of your Benefit Plan, are considered purely cosmetic dentistry, and are not Covered Services. (See attached Schedule of Benefits for detailed information.). If the Member elects to receive a porcelain, composite or acrylic crown restoration that is not a Covered Service, the Member must pay the Participating Provider's charges that exceed the Copayment for a full cast metal crown.

C. Periodontics

The following Periodontal Services are not covered unless specifically identified in the Schedule of Benefits:

1. Crown Lengthening – Surgical procedure involving the removal of gingival and supporting bone to expose more tooth structure in preparation for a crown procedure is not covered unless specifically listed as a Covered Service of your Benefit Plan. (See

attached Schedule of Benefits for detailed information.)

2. Bone Grafts – Use of various forms of graft to stimulate bone formation is not covered unless specifically listed as a Covered Service of your Benefit Plan. (See attached Schedule of Benefits for detailed information.)

3. Soft Tissue Graft – Use of gingival as a graft to repair a gingival defect or an exposed root is not covered unless specifically listed as a Covered Service of your Benefit Plan. (See attached Schedule of Benefits for detailed information.)

4. Full Mouth Debridement – Removal of plaque and calculus that obstruct the ability to perform an evaluation. This procedure is not covered unless specifically listed as a Covered Service of your Benefit Plan. (See attached Schedule of Benefits for detailed information.)

D. Prosthodontics, Removable

1. Lost, stolen, or damaged appliances due to Member abuse is not covered.

2. Removable Prosthetic Services and supplies that are cosmetic in nature.

3. Implant supported prostheses are not a Covered Service.

4. Charges for specialized techniques involving precision attachments, and personalization or characterization of such appliances are not covered.

5. Overdentures (dentures that overlie, and are supported by, a retained tooth root or a dental implant) are not covered.

E. Prosthodontics, Fixed (Fixed Partial Dentures or Bridges)

1. Lost, stolen, or damaged Fixed Partial Dentures , due to Member abuse is not covered.

2. Distal extension posterior cantilever pontics, which are supported at the front end only, are not covered.

3. Implant supported prostheses are not a Covered Service.

4. Correction of Occlusion or “occlusal equilibration” when performed independently of a completed restoration of a prosthesis may be recommended to treat Temporomandibular Joint Disorders (TMJ) or Myofacial pain. In such instances, correction of occlusion is not covered, since this Benefit Plan does not cover treatments of disturbances of the TMJ.

5. Facing on pontics and crowns posterior to the second bicuspid are considered to be cosmetic and are not covered, unless specifically listed as a Covered Service of your Benefit Plan (See attached Schedule of Benefit for detailed information.). If the Member elects to receive facing on pontics or crowns that are not a Covered Service, the Member must pay the Participating Provider’s charges that exceed the Copayment for a full metal crown as described in the Schedule of Benefits.

6. Fixed Partial Dentures are not covered if the Member is missing teeth on opposite sides of the same arch, because a Removable Partial Denture is considered an adequate replacement. If the Member elects to receive a Fixed Partial Denture, the Member must pay the Participating Provider’s charges that exceed the Copayment for a Removable Partial Denture as set forth in the Schedule of Benefits. This exclusion does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

7. Fixed Partial Dentures are not covered unless a Removable Partial Denture cannot satisfactorily restore the case according to professionally recognized standards of dental practice. This limitation does not apply if the treating Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

8. Fixed Partial Dentures are not covered when abutment teeth are healthy and would be crowned only for the purpose of supporting a pontic. If Fixed Partial Dentures are used under these circumstances, it is considered elective and is not a Covered Service, and the Member must pay the Participating Provider’s charges that exceed the Copayment for a Removable Partial denture as specified in the Schedule of Benefits. This limitation does not apply if the treating

Participating Provider determines that such services are necessary for the dental health of the Member consistent with professionally recognized standards of dental practice.

F. Oral Surgery: The following surgical procedures are not covered unless specifically identified as Covered Services in the Schedule of Benefits.

1. Biopsy – The process of removing tissue for histologic evaluation.

2. Alveoloplasty and Tuberosity Reduction – The process of reshaping of the bone supporting a dental prosthesis.

3. Removal of Tori and Exostosis – The process of removal of overgrown bony protuberances.

4. Intraoral Incision and Drainage (I & D) – The process of drainage of an abscess through an incision.

5. Frenectomy – The process of elimination of muscle fibers attaching the cheek, lips, and tongue to associated dental mucosa.

6. Excision of Hyperplastic Tissue – The process of removing overgrown soft tissue from the oral cavity.

G. Orthodontics

The following services are not covered under the orthodontic benefit :

1. TMJ/Myofunctional Therapy –Therapy for treatment of jaw joint problems, and teaching and therapy for improper swallowing and tongue posture are not covered.

2. Surgical Orthodontics – Surgical Orthodontics to reposition the jaw bones and teeth is not covered.

3. Treatment of Cleft Palate – Treatment for problems involving holes or voids in the bone that forms the roof of the mouth is not covered.

4. Orthognathic Surgery – Surgery to move the jaw bones into alignment is not covered.

5. Removable Orthodontic Appliance Therapy – The use of appliances that are removable from the mouth by the Member and which are used to hold or move and align teeth are not covered.

6. Treatment of Hormonal Imbalances – The treatment of hormone imbalances that influence growth and influence the ability of teeth to move without root damage is not covered.

7. Class III Orthodontics – Treatment for problems with the growth relationship of the upper and lower jaw resulting in positioning of the lower jaw or teeth in front of the upper jaw or teeth is not covered.

8. Orthodontic Treatment Commenced Prior to Coverage – An orthodontic treatment program which commenced before the Member enrolled in this Benefit Plan is not covered.

9. Retreatment of Orthodontic cases – The treatment of orthodontic problems that have been treated before are not covered.

10. Lost, Stolen, Damaged or Broken Appliances – Damaged or lost retainers, brackets, bands, wires or other materials supplied by the orthodontist are not covered.

11. Extractions for Orthodontic Purposes -Removal of teeth specifically to correct orthodontic problems or due to lack of eruptive space are not covered.

H. General Exclusions

The following general exclusions are applicable to all services:

1. Treatment by someone other than a Participating Provider and/or duly qualified technician under the direction of a Participating Provider except for Emergency treatment as provided in Section VIII., or upon prior authorization by the Plan.

2. Charges for medical treatment, prescriptions, or other non-dental charges incurred.

3. Hospitalization costs for any dental procedure, including all hospital services and medications, will be borne by the Member. When deemed medically necessary by the Member's physician and preauthorized by the Plan, otherwise covered dental services that are delivered in an inpatient or outpatient hospital setting are Covered Services under the Benefit Plan. See attached Schedule of Benefits for applicable Copayments. All other associated expenses, includ-

ing general anesthesia and IV conscious sedation, remain the responsibility of the Member.

4. Treatment of malignancies, neoplasms, and cysts.

5. Treatment of disturbances of the Temporomandibular Joint (T.M.J.).

6. Procedures, restorations, and appliances to correct congenital or developmental malformations.

7. Services and supplies which are not deemed necessary for a Member's dental health in accordance with professionally recognized standards of dental practice are not covered.

8. Dental expenses incurred in connection with any dental procedure started after termination of coverage.

9. Dental expenses incurred in connection with any portion of the dental services provided prior to the effective date of coverage are excluded.

10. Appliances to correct and control harmful habits are not covered (e.g. tongue thrust and thumb sucking), unless specified in the accompanying Schedule of Benefits (See attached Schedule of Benefits for detailed information.). This exclusion is not intended to eliminate coverage for dental services based on the cause of the underlying condition being treated.

San Diego County Teamsters
Employers Insurance Trust

Elective Treatment

When the patient selects a plan of treatment that is beyond the actual covered benefit, the Plan will allow the applicable fee for the covered benefit. The patient is responsible for the entire remainder of the dentist's fees in addition to the applicable copayment for the covered service. For example:

ELECTIVE TREATMENT FORMULA

Dentist UCR for elective treatment (i.e. fixed bridge)	$	1200.00
Dentist UCR for covered treatment (i.e. partial denture)		-750.00
Difference between elective & covered treatments	$	450.00
Applicable copayment for covered treatment (partial denture)		+100.00
*Total patient copayment	$	550.00

*Note: This copayment does not include the member's lab cost for gold.

The Evidence of Coverage Booklet Defines:

Aesthetic Dentistry: Any dental procedure performed purely for cosmetic purposes and where there is no restorative value.

Elective Dentistry: Any dental procedure unnecessary to the dental health of the patient, as determined by a Plan Dentist.

Second Dental Opinions

A Member or Participating Provider may request a second opinion consultation by writing or calling the Plan's Member Services Department by telephone at **1-800-992-3366** or in writing at P.O. Box 14227, Orange, CA 92863. Decisions and notifications regarding requests for second opinion consultations will be rendered within the following time limits: For routine second opinion requests, the decision to approve or deny requests for second opinion consultations will be made within 5 business days of the Plan's receipt of the request. For urgent requests, the second opinion will be authorized or denied within 72 hours of the Plan's receipt of the request. The requesting Participating Provider will be notified both verbally and in writing within 24 hours of the decision. The decision will be communicated to a requesting Member verbally (when possible) and in writing within 2 business days.

A second opinion consultation may be authorized for surgical procedures, unclear or complex and confusing clinical indications, conflicting test results, the Participating Provider's inability to diagnose the Member's condition, a treatment plan in progress but not improving the Member's condition within an appropriate time period, or the Member's serious concerns about a particular diagnosis or plan of care. A written Explanation of Benefits will be issued to the Member and the Member's Participating Provider, including the name and location of the second opinion provider if the second provider if the second opinion is approved. Upon approval, the Plan will refer the Member's Participating Provider who is under contract with the Plan. Should there be no available Participating Provider in the appropriate geographical area, the Plan will refer the Member to a non-participating Provider for a second opinion consultation. A Plan representative will assist an appointment. The second opinion provider will submit the claim for payment to the Plan. The Member is only responsible for the applicable copayment as set forth in the Schedule of Benefits. The Plan will pay any cost in excess of the applicable copayment and will contact the provider rendering the second opinion to advise of Western Dental's payment in excess of the Copayment.

The second opinion provider will provide the Member and the Member's Participating Provider with a written narrative report of the results of the Member's consultation. All treatment must be performed by the Member's Participating Provider for the Member to received Covered Services under the Benefit Plan. This shall not limit the Member's right to transfer to another Participating Provider in order to receive Covered Services under the Benefit Plan.

VI.

UTILIZATION & REPORTING

UTILIZATION & REPORTING

The following section contains important information regarding provider responsibility for utilization and reporting as well as the guidelines or criteria used by WDS for Utilization Review decisions.

REPORTING MEMBER UTILIZATION

The ADA claim form is to be used to report services provided to Western Dental Services, Inc. members. Use one form per patient. The completed forms are to be mailed to WDS corporate office by the 10th of the month.

WDS Member Services department processes completed services indicated on the ADA claim form. This information is used to determine the utilization of dental procedures being provided in your office to our members.

Computer print outs will be accepted if your office is able to produce them with the same information as the ADA claim form. This is important for the tabulation and reporting of the data. WDS uses the current Dental Quality Alliance (DQA) utilization metrics when reviewing member utilization.

If you have any questions, please call the Provider Relations Department at **1-800-811-5111.**

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifie ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited b law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 2 =O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident	
46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number	52a. Additional Provider ID	

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number	58. Additional Provider ID

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION IV – UTILIZATION MANAGEMENT	
IV.B-UM Guidelines or Criteria	
UMC Chair:	Approved on:
QIC Chair:	Approved on:

IV.B1 - UTILIZATION MANAGEMENT GUIDELINES POLICY

It is the policy of Western Dental Services, Inc., ("WDS"), to ensure that when Utilization Review decisions are based in whole or in part on the medical necessity of the proposed dental health care services, that any such Utilization Review decisions are consistent with criteria or guidelines that are supported by sound clinical principles and processes.

The Quality Improvement Committee ("QIC") oversees and approves the development of, and the updates to, the Utilization Management Guidelines. The Utilization Management Committee, by way of a Utilization Management Guidelines Subcommittee, whose membership includes general dental and specialty providers participating in the network, develops and, at least annually, reviews and updates, whenever necessary, the criteria and guidelines for making dentally appropriate decisions that are consistent with accepted professional standards of care, such as the Clinical Guidelines of the American Academy of Pediatric Dentistry, the Parameters of Care of the American Academy of Periodontology, the Selection of Patients for X-ray Examinations: Dental Radiographic Examinations by the U.S. Department of Health and Human Services, and the Guidelines and Position Statements of the American Association of Endodontists. These guidelines shall take into account the health, age, tolerance of physical and emotional stress of the member, as well as the medical necessity and appropriateness of the treatment, with evidence of need. Treatment should result in acceptable quality of care and acceptable, predictable treatment outcomes.

These guidelines may be superseded by plan-specific coverage guidelines.

IV.B2 - UTILIZATION MANAGEMENT GUIDELINES

WDS Utilization Management Guidelines are attached hereto.

IV.B3 - SCOPE

The scope of the UM Program and its policies shall include WDS Staff Model Offices, individual Primary Care Dentists (PCD) and Specialists.

WESTERN DENTAL SERVICES, INC.
UTILIZATION MANAGEMENT REVIEW GUIDELINES

It is the policy of Western Dental Services, Inc., ("WDS"), that a qualified licensed dentist shall supervise the review of all decisions related to requests for authorization of health care services for a member. All decisions to deny, modify or defer a request for authorization ("prospective review") or requests for payment for health care services ("retrospective review") based in whole or in part on medical necessity must be made by a qualified licensed dentist.

Any reviews must take into consideration sufficient documentation and evidence to confirm the need for the requested or provided health care services. Treatment should result in acceptable quality of care and acceptable, predictable treatment outcomes. The requested procedure must be a covered benefit of the program/plan.

Unless otherwise stated in benefit plan documents, the following guidelines are used by WDS for utilization management decisions based in whole or in part on medical necessity.

I. GUIDELINES FOR AUTHORIZATIONS FOR REFERRALS

The following Utilization Review guidelines apply for Requests for Referral benefits for procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits.

I.OS **Oral Surgery Referrals**
Provider Requirements for Submission:

Third Molar Extractions:

I. OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

I. OS.2 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

I. OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the proper eruption or restoration of the adjacent second molar or causes potential damage to the second molar.

I. OS.4. The PCD should document for each individual tooth the evidence of need for the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

I. OS.5 The age and the health of the member and the member's current dental condition should be carefully considered (e.g. removal of asymptomatic 3rd molar extractions may not be recommended for members over the age of 26 years without evidence of pathology or symptoms that cannot be treated in another fashion due to the increased risk of complications such as ankylosis and jaw fracture).

I. OS.6 Alternative treatments (including no treatment), benefits and risks to the member with regards to the extraction of the 3rd molar, should be considered.

I.OS.7 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment, and benefits for treatment that meet the benefit criteria should be approved with the referral. However, this is within the discretion of the dentist reviewer.

Non-Third Molar Extractions and Other Covered Surgical Procedures:

I. OS.8 There must be adequate quantity and quality of radiographs, photographs, other images, etc. to support the diagnosis and classification of the procedure.

I. OS.9 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

I. OS.10 The condition of the tooth or the surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

I. OS.11 Alternative treatments (including no treatment), benefits and risks to the member with regards to the procedure(s) should be considered.

Criteria for Approval of Benefits:

I.OS.12 Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a general practitioner. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.); surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided by a general dentist.

I.OS.13 For members who are not edentulous, referrals for implant consultation must include a full series of radiographs and a comprehensive restorative treatment plan for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

I.OS.14 For members who are not edentulous, referrals for implant placement must include a full series of radiographs, a comprehensive restorative treatment plan, and a notation designating the intended restorative facility - the referring restorative office or another contracting WDS office - for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

General Anesthesia and Sedation Considerations for Oral Surgery Referrals:

I.OS.15 Consider the increased risks associated with general anesthesia and sedation.

I.OS.16 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of pain/anxiety control.

f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

I.OS.17 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. To alleviate member apprehension, nervousness, fear, or behavior management (except for pediatric members or physically compromised or mentally challenged adult members, as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits or Modification of procedure:

I.OS.18 Patient is no longer eligible or a member.
I.OS.19 Procedure is not a covered benefit under the plan or the program.
I.OS.20 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
I.OS.21 There is no submitted evidence of need.
I.OS.22 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for referral benefits for those services that are within the scope of services typically provided by general dentists.
I.OS.23 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits due to insufficient submitted materials to meet the requirements for benefit determination:

NOTE: Providers may resubmit the Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.OS.24 PCD requirements for submission have not been met.
I.OS.25 Additional information is needed in order to make a determination.
I.OS.26 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document the tooth number and/or service requested, or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, history of BRONJ, IV bisphosphonate usage, xerostomia, radiation exposure, etc.))

I.E **Endodontic Referrals**

Provider Requirements for Submission:

I.E.1 The PCD must submit a diagnostic PA of the tooth or area of concern (as well as a bitewing for posterior teeth) and mounted (with the left and right sides distinguished) and dated additional radiographs to establish integrity of the arch, the strategic value of retaining the tooth, and its contribution to the dentition as a whole. The referral will be denied for incomplete submission if the radiographic documentation is incomplete, unless

it is an emergency requiring treatment within 72 hours and the non-radiographic documentation adequately supports approval of the referral.

I.E.2 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment, and benefits for treatment that meet the benefit criteria should be approved with the referral. However, this is within the discretion of the dentist reviewer.

I.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth, with no indication of reasonable plans for replacement of the opposing tooth). The submitting provider may be asked to submit supplemental narrative documentation whenever possible to establish need for the requested procedure(s).

I.E.3.b Benefits are not available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable furcal or inter-proximal involvement, excessive mobility or inadequate bone support.

I.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, unfavorable crown-to-root ratio with advanced bone loss.

I.E.4 Cases with no radiographic and/or documented evidence of need for treatment will result in a denial. Evidence of need may include, but is not limited to, diagnosis of extensive caries affecting the pulp, periapical pathology or symptoms indicating the existence of infection due to degeneration of the pulp, or irreversible pulpitis of the tooth.

I.E.5 If the tooth has a perio-endo lesion, then a periodontal consultation should be done prior to the completion of the endodontic procedure to ensure that the tooth has a reasonable prognosis. The periodontal consultation is necessary to determine and document whether the treatment can result in a predictable, successful outcome. However, when necessary, pain relief should be provided to the member by the PCD or, in difficult cases, by the endodontist prior to the periodontal referral, including but not limited to prescribing pain medication, occlusal adjustment, extirpation of a portion or all of the pulp, placement of a temporary restoration, extraction (in some cases), etc.

I.E.6 Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial. The PCD can submit written documentation with regards to the member's compliance with oral hygiene and compliance with seeking regular dental treatment.

I.E.7 The endodontic services that are within the scope of services typically performed by PCDs include diagnostic procedures performed to establish the need for endodontic treatment, RCTs on all anterior teeth, bicuspids and most molars, unless documentation provided by the PCD suggests otherwise. WDS considers the performance of pulp testing to be included in the covered examination.

Criteria for Approval of Benefits:

I.E.8 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but not be limited to the following: additional covered diagnostics necessary to establish need for the requested procedure, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots

(dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, treatment of canal obstructions and/or hemisections.

Criteria for clinical or contractual Denial of Benefits:

I.E.9 Patient is no longer eligible or a member.
I.E.10 Procedure is not a covered benefit under the plan or the program.
I.E.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
I.E.12 There is no evidence of need or the treatment of the tooth will not improve/restore function.
I.E.13 The information submitted by the PCD about the member's current dental condition does not meet the minimum requirement for approval of the service.
I.E.14 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval. WDS does not generally provide benefit for endodontic treatment for teeth requiring hemisection or root amputation.
I.E.15 Root fracture or continuous vertical coronal fracture that is subosseous.
I.E.16 Periodontal disease has destroyed the bone around the tooth.
I.E.17 Inadequate bone support.
I.E.18 The procedure is determined to be within the scope and/or responsibility of the PCD.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: PCDs may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.E.19 PCD requirements for submission have not been met.
I.E.20 Additional information is needed in order to make a determination.
I.E.21 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

I.PD **Pediatric Dentistry Referrals**

Provider Requirements for Submission:

I.PD.1 The PCD must submit mounted (with the left and right sides distinguished) and dated full mouth radiographs. The radiographs submitted should be diagnostic and of acceptable quality. The PCD must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.
I.PD.2 The provider must document why treatment of the member is not within the scope of the provider. In cases where the member is uncooperative, the provider must document the dates of any unsuccessful attempts to treat the member.

Criteria for Approval of Benefits:

I.PD.3 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

I.PD.4 There is no age restriction for GMC/LAPHP members.

I.PD.5 In cases where there are no radiographs submitted with the request for referral benefits, consideration of authorization/payment will be based on the pre-operative radiographs or appropriate photographs taken at the pediatric dental office.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Considerations for Pediatric Dentistry Referrals:

I.PD.6 Consider the increased risks associated with sedation.

I.PD.7 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. The definition of "prolonged" (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

I.PD.8 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits:

I.PD.9 Patient is no longer eligible or a member.

I.PD.10 Procedure is not a covered benefit under the plan or the program.

I.PD.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

I.PD.11 The procedure is within the scope and/or responsibility of the PCD (e.g. prophy).

Criteria for Denial of Benefits Request due to insufficient submitted materials:
NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.PD.12 PCD requirements for submission have not been met.

I.PD.13 Additional information is needed in order to make a determination.

I.PD.14 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information such as incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc.).

I.PR **Periodontal Referrals**

Provider Requirements for Submission:

I.PR.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 12 months of the request). The provider must document if and why radiographs cannot be obtained.

I.PR.2 The PCD must document why treatment of the member is not within the scope of the PCD (e.g. surgical case, medically compromising conditions, etc.).

I.PR.3 The member should have had pre-treatment pocket charting, timely scaling and root planing (SRP) and a post-treatment re-evaluation. Pocket charting should be recorded at the re-evaluation. In addition, the member must have had at least one periodontal maintenance visit (usually 3-4 months after scaling and root planing) by the PCD within 4 months of the referral request, with recording of pocket charting, prior to referral to the periodontist for surgical treatment of periodontal disease.

I.PR.4 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Periodontal chart must be dated.

I.PR.5 A periodontist may be consulted to assist the PCD with treatment planning.

I.PR.6 Evaluation by the PCD, including member compliance and prognosis, should be present.

Criteria for Approval of benefits:

I.PR.7 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for the treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection, or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene and/or other supplemental therapeutic protocol:
Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces
Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.

I.PR.8 Evidence of need should be supported by proper periodontal charting, radiographic evidence of bone loss and the presence of calculus, and, when necessary, written documentation by the PCD. An adequate level of home care and oral hygiene must be documented. The PCD must submit the following documentation for approval of specialty treatments: 1) pocket charting from the initial examination, the periodontal re-evaluation, when available, and the periodontal maintenance visit.

I.PR.9 A periodontal consultation may be approved if the PCD needs assistance with treatment planning and sequencing.

Criteria for clinical and contractual Denial of Benefits:

I.PR.10 Patient is no longer eligible or a member.

I.PR.11 Procedure is not a covered benefit under the plan or the program.

I.PR.12 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

I.PR.13 The procedure is within the scope and/or responsibility of the PCD (e.g. scaling and root planing).

I.PR.14 Poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II or greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis or need for referral not established. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.PR.15 PCD requirements for submission have not been met.

I.PR.16 Additional information is needed in order to make a determination.

I.PR.17 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information when needed by the reviewer to establish need for the procedure or reasonable prognosis, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factor, xerostomia, radiation exposure, etc.).

II. GUIDELINES FOR REVIEW OF PRE-AUTHORIZATIONS

The following Utilization Review guidelines apply for requests for Pre-Authorization of benefits for procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits.

II.OS **Oral Surgery Pre-Authorizations**
Provider Requirements for Submission:

Third Molar Extractions:

II. OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

II. OS.2 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

II. OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the proper eruption or restoration of the adjacent second molar or causes potential damage to the second molar.

II. OS.4. The provider should document for each individual tooth the evidence of need for the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

II. OS.5 The age and the health of the member and the member's current dental condition should be carefully considered (e.g. removal of asymptomatic 3rd molar extractions may not be recommended for members over the age of 26 years without evidence of pathology or symptoms that cannot be treated in another fashion due to the increased risk of complications such as ankylosis and jaw fracture).

II. OS.6 The condition of the tooth and the surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

II. OS.7 Alternative treatments (including no treatment), benefits and risks to the member with regards to the extraction of the 3rd molar should be considered.

Non-Third Molar Extractions and Other Covered Surgical Procedures:

II. OS.8 There must be adequate quantity and quality of radiographs to support the diagnosis and classification.

II. OS.9 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

II. OS.10 The condition of the tooth or surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

II. OS.11 Alternative treatments (including no treatment), benefits and risks to the member with regards to the procedure(s) should be considered.

II.OS.12 For members who are not edentulous, requests for benefits for implant placement must include a full series of radiographs, a comprehensive restorative treatment plan, and a notation designating the intended restorative facility - the referring restorative office or another contracting WDS office - for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

Criteria for Approval of Benefits:

II.OS.13 Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a general practitioner. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.);

surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided a general dentist.

General Anesthesia and Sedation Considerations for Oral Surgery Pre-Authorizations:

II.OS.14 Consider the increased risks associated with general anesthesia and sedation.

II.OS.15 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of pain/anxiety control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

II.OS.16 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. To alleviate member apprehension, nervousness, fear, or behavior management (except for pediatric members or physically compromised or other mentally challenged adult members, as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits or Modification of procedure:

II.OS.17 Patient is no longer eligible or a member.

II.OS.18 Procedure is not a covered benefit under the plan or the program.

II.OS.19 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.OS.20 There is no submitted evidence of need.

II.OS.21 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for pre-authorization of services that are within the scope of services typically provided by general dentists.

II.OS.22 Procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request: Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.OS.23 PCD requirements for submission have not been met.

II.OS.24 Additional information is needed in order to make a determination.

II.OS.25 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, history of BRONJ, IV bisphosphonate usage, xerostomia, radiation exposure, etc.)

II.E Endodontic Pre-Authorizations

Provider Requirements for Submission:

II.E.1 The provider must submit a diagnostic PA of the tooth (as well as a bitewing for posterior teeth) and mounted (with the left and right sides distinguished) and dated additional radiographs to establish integrity of the arch, the strategic value of retaining the tooth, and its contribution to the dentition as a whole. The pre-authorization will be denied for incomplete submission if the radiographic documentation is incomplete, unless it is an emergency requiring treatment within 72 hours and the non-radiographic documentation supports approval of the pre-authorization.

II.E.2 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment and benefits for treatment that meet the benefit criteria should be approved. However, this is within the discretion of the Dental Consultant reviewer.

II.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth). The provider may be asked to submit supplemental narrative documentation whenever possible to establish need for the requested procedure(s).

II.E.3.b Benefits are not available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable inter-proximal or furcal involvement, excessive mobility or inadequate bone support.

II.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, unfavorable crown-to-root ratio with advanced bone loss.

II.E.4 Cases with no radiographic and/or documented evidence of need for treatment will result in a denial. Evidence of need may include, but is not limited to, diagnosis of extensive caries affecting the pulp, periapical pathology or symptoms indicating the existence of infection due to degeneration of the pulp, or irreversible pulpitis of the tooth.

II.E.5 If the tooth has a perio-endo lesion, then a periodontal consultation should be done prior to the completion of the endodontic procedure to ensure that the tooth has a reasonable prognosis. The periodontal consultation is necessary to determine and document whether the treatment can result in a predictable, successful outcome. However, when necessary, pain relief should be provided to the member by the PCD or, in difficult cases, by the

endodontist prior to the periodontal referral, including but not limited to prescribing pain medication, occlusal adjustment, extirpation of a portion or all of the pulp, temporary restoration, etc.

II.E.6 Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial.
The provider can submit written documentation with regards to the member's compliance with oral hygiene and compliance with seeking regular dental treatment. II.E.7 The endodontic services that are within the scope of services typically performed by PCDs include diagnostic procedures performed to establish the need for endodontic treatment. RCTs on all anterior teeth, bicuspids, and most molars, unless documentation provided by the PCD suggests otherwise. WDS considers the performance of pulp testing to be included in the covered examination.

Criteria for Approval of Benefits:

II.E.8 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but not be limited to the following: additional covered diagnostics necessary to establish the need for the procedure, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots (dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, treatment of canal obstructions and/or hemisections. Any available diagnostics performed by the referring PCD should be provided to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Benefits for treatment of obstruction are considered inclusive in the global procedure for root canal therapy for instances of endodontic re-treatments, calcified canals and other calcifications such as pulp stones. Benefits for the removal of existing posts, pins and build-ups are considered to be inclusive in the procedure for endodontic re-treatment. However, at the discretion of the dentist reviewer, benefits may be available for other obstructions such as separated instruments, etc. The use of specialized materials (e.g. MTA, MTAD, etc.) is generally considered to be included in the procedure. No additional benefit is provided for specialized materials.

Criteria for clinical or contractual Denial of Benefits:

II.E.9 Patient is no longer eligible or a member.

II.E.10 Procedure is not a covered benefit under the plan or the program.

II.E.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.E.12 There is no evidence of need or the treatment of the tooth will not improve/restore function.

II.E.13 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service.

II.E.14 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval. WDS does not generally provide benefit for endodontic treatment for teeth requiring hemisection or root amputation.

II.E.15 Root fracture or continuous vertical coronal fracture subosseous.

II.E.16 Periodontal disease has destroyed the bone around the tooth.

II.E.17 Inadequate bone support.

II.E.18 The procedure is determined to be within the scope and/or responsibility of the PCD.

Criteria for Denial of Benefits Request due to insufficient submitted materials:
NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request: Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.E.19 Requirements for submission have not been met.

II.E.20 Additional information is needed in order to make a determination.

II.E.21 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect/wrong tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

II.PD Pediatric Dentistry Pre-Authorizations

Provider Requirements for Submission:

II.PD.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full mouth radiographs. The radiographs submitted should be diagnostic and of acceptable quality. The provider must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.

II.PD.2 Evidence of need for requested benefits, include, but are not limited to, a diagnosis of decay, fracture, infection or other dental condition with supporting radiographs and/or narrative.

Criteria for Approval of Benefits:

II.PD.3 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

II.PD.4 There is no age restriction for GMC/LAPHP members.

II.PD.5 In cases where there are no radiographs submitted with the request for pre-authorization, consideration of authorization/payment will be based on the pre-operative radiographs and/or appropriate photographs taken at the time of treatment. The radiographs submitted should be diagnostic and of acceptable quality.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Considerations for Pediatric Dentistry Pre-Authorizations:

II.PD.6 Consider the increased risks associated with sedation.

II.PD.7 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.

b. Spastic-type handicapping condition.

c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

II.PD.8 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or when there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial or Modification of Benefits:

II.PD.9 Patient is no longer eligible or a member.
II.PD.10 Procedure is not a covered benefit under the plan or the program.
II.PD.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
II.PD.12 Insufficient evidence of need or the procedure is within the scope and/or responsibility of the PCD (e.g. prophy).
II.PD.13 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.PD.14 PCD requirements for submission have not been met.
II.PD.15 Additional information is needed in order to make a determination.
II.PD.16 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc.).

II.PR <u>Periodontal Pre-Authorizations</u>

Provider Requirements for Submission:

II.PR.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 12 months of the request). The provider must document if and why radiographs cannot be obtained.
II.PR.2 If not obvious, the provider must document why treatment of the member is not within the scope of the PCD (e.g. surgical case, medically compromised, etc.).

II.PR.3 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Most recent periodontal chart must be dated and within 4 months of the pre-authorization request.

II.PR.4 Evaluation, including member compliance and prognosis, should be present.

Criteria for Approval of Benefits:

II.PR.5 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene, and/or supplemental therapeutic protocols:

Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces

Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.II.PR.6

Evidence of need should be supported by proper periodontal charting (dated within 4 months of the preauthorization request), radiographic evidence of bone loss and/or the presence of calculus, or written documentation by the provider. Evidence of need may include, but is not limited to, a diagnosis of periodontal disease as well as narrative and submitted documentation supporting a clinical judgment that surgical intervention will most likely provide for disease control and retention of teeth in question for at least 3 years with little chance for additional surgical intervention during that time period.

Criteria for clinical and contractual Denial or Modification of Benefits:

II.PR.7 Patient is no longer eligible or a member.

II.PR.8 Procedure is not a covered benefit under the plan or the program.

II.PR.9 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.PR.10 The procedure is within the scope and/or responsibility of the PCD (e.g. scaling and root planing), evidence of need is not demonstrated for the procedure, there is a poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II or greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

II.PR.11 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.PR.12 Requirements for submission have not been met including the appropriate provision of initial pre-surgical therapy by the PCD.

II.PR.13 Additional information is needed in order to make a determination.

II.PR.14 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or

supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

II.R **<u>Restorative Dentistry Pre-Authorizations</u> (including filling restorations, crowns, bridges, implant-supported restorations and removable prosthetics)**

Provider Requirements for Submission:

II.R.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs. The provider must document if and why radiographs cannot be obtained. When full mouth radiographs are not available, a sufficient number of radiographs (tooth in question, opposing arch, and contralateral views) and appropriate views (periapical, bitewing and/or panoramic radiographs) to justify the proposed treatment must be submitted.

II.R.2 Diagnostic copies or original radiographs are acceptable.

II.R.3 Evaluation by the PCD including member compliance, overall prognosis (periodontic and endodontic) and the amount of available tooth structure should be documented for such procedures as crowns, bridges, and removable partial dentures. Evidence of history of poor oral hygiene, poor member self-care may result in denial.

Criteria for clinical or contractual Denial or Modification of Benefits Request:

II.R.4 Patient is no longer eligible or a member.

II.R.5 Procedure is not a covered benefit under the plan or the program.

II.R.6 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program

II.R.7 There is no documentation of evidence of need. Evidence of need may include, but is not limited to, radiographs, written narrative documentation, photos, and/or models supporting a diagnosis of decay, fracture, infection or other condition.

II.R.8 There is a more conservative treatment option within the professional standard of care (e.g. filling vs. crown, filling vs. prophylactic pulpotomy, etc.).

II.R.9 There exists an infection that must be treated prior to the requested procedure, or a procedure is requested when another procedure is required prior to the requested procedure for the optimal outcome, (i.e. treatment is not consistent with the optimal treatment sequence).

II.R.10 The tooth or implant does/would not have the adequate bone support and/or tooth structure for a favorable outcome.

II.R.11 The tooth, implant or proposed implant position is in an abnormal or unusual position, cannot be restored satisfactorily, or the restoration will not improve/restore function (e.g. lack of opposing tooth or pontic, lack of adequate arch integrity or inadequate occlusion).

II.R.12 The final restoration may be denied if a previously completed RCT is unsatisfactory, unstable, and/or symptomatic (e.g. incomplete, short fill, overfill, silver points, Sargenti paste, etc.).

II.R.13 Removable prosthesis or restoration/placement of implants may be denied due to physical limitations, systemic involvement, or emotional disturbances.

II.R.14 Adequate space is required for approval of replacement of tooth/teeth or restoration/placement of implants.

II.R.15 Procedure is not indicated in a primary tooth because the primary tooth will be replaced in the arch (e.g. laboratory fabricated crowns).

II.R.16 Replacement teeth may be denied when 1) there are adequate teeth in the arch to support the existing teeth for proper mastication (biting and chewing) and function and to prevent tooth movement or shifting (e.g. replacement of long-standing missing teeth in a stable occlusion), 2) Removable Partial Dentures or implants to replace 2nd and 3rd molars where there are no functional opposing teeth..

II.R.17 Benefits may be available only for the most inclusive procedure when covered by the plan.

II.R.18 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

II.R.19 When there is more than one restorative procedure that could adequately address the dental condition requiring treatment, the procedure may be recoded to the least-expensive acceptable service covered by the plan.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.R.20 PCD requirements for submission have not been met.

II.R.21 Additional information is needed in order to make a determination.

II.R.22 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of IV bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III. GUIDELINES FOR AUTHORIZATIONS FOR CLAIMS PAYMENT

The following Utilization Review guidelines apply for requests for Claims Payment for completed procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits. Retrospective review of treatment rendered may be appropriate when treatment did not undergo required prospective review, or when treatment rendered varied from the treatment previously reviewed and approved.

III.OS **Oral Surgery Claims**

Provider Requirements for Submission:

Third Molar Extractions

III.OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

III.OS.2 There must be acceptable radiographic, written, photographic, or other imaging justification for the need for the extraction(s).

III.OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar only when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the eruption or restoration of the adjacent second molar or causes potential damage to the second molar..

III.OS.4 The provider should document for each individual tooth the evidence of need for completing the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

Non-Third Molars Extractions and Other Covered Surgical Procedures

III.OS.5 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

III.OS.6 Consultation fees are not covered when done on the same day as surgery. In the case of verifiable emergency referrals, exceptions may be made by the dentist reviewer.

III.OS.7 Requests for payment for removal of cysts, biopsies, etc., must be accompanied by a report.

Criteria for Approval of Payment:

III.OS.8 Evidence of need for the procedure. Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a PCD. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.); surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided by a general dentist.

III.OS.9 Signed and dated claim form evidencing that procedure was performed.

III.OS.10 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment. However, this is within the discretion of the dentist reviewer.

General Anesthesia and Sedation Consideration for Oral Surgery Claims:

III.OS.11 Consider the increased risks associated with general anesthesia and sedation.

III.OS.12 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but not be limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternate method of pain/anxiety control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

III.OS.13 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. To alleviate member apprehension, nervousness, fear, behavior management (except for pediatric members or physically compromised or other mentally challenged adult members as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial or Modification of Claims for Payment:

III.OS.14 Patient was not eligible at the time of service.
III.OS.15 Procedure was not a covered benefit under the plan or the program.
III.OS.16 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
III.OS.17 There was no submitted evidence of need.
III.OS.18 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for payment for services that are within the scope of services typically provided by general dentists.
III.OS.19 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.
III.OS.20 Extraction of a tooth that has not been pre-authorized and/or was not planned for extraction.

Criteria for Denial of Claim Payment due to insufficient submitted materials

NOTE: Providers may resubmit Claims with additional materials for review as a new request.
III.OS.21 Requirements for submission had not been met (e.g. PCD did not properly refer).
III.OS.22 Additional information is needed in order to make a determination.
III.OS.23 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.E **Endodontic Claims**

Provider Requirements for Submission:

III.E1 The provider should submit dated diagnostic pre-op and post-op radiographs of the tooth for accurate and complete evaluation. The claim will be denied for incomplete submission if the radiographic documentation is incomplete.

III.E.2 If it is obvious that the treatment was needed, no written explanation is needed. Otherwise narrative may be helpful to ensure payment of completed services.

III.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth with no indication of reasonable plans for replacement of the opposing tooth).

III.E.3.b Benefits are not generally available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable furcation involvement, excessive mobility or a poor crown root ratio.

III.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, inadequate bone support.

Criteria for Approval of Payment:

III.E.4 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of a PCD. This may include, but not be limited to the following: diagnostic procedures to establish the need for the performed treatment, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots (dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, , treatment of canal obstructions and/or hemisections. WDS considers pulp testing to be included in the covered examination. Any available diagnostics should be provided by the PCD to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Any available diagnostics should be provided by the PCD to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Benefits for treatment of obstruction are considered inclusive in the global procedure for root canal therapy for instances of endodontic re-treatments, calcified canals and other calcifications such as pulp stones. In the case of re-treatments, the removal of existing posts, pins and build-ups is considered to be included in the benefit for the re-treatment procedure. However, at the discretion of the dentist reviewer, benefits may be available for other obstructions such as separated instruments, etc. The use of specialized materials (e.g. MTA, MTAD, etc.) is generally considered to be included in the procedure. No additional benefit is provided for specialized materials.

III.E.5 The root canal procedure appears to be properly accessed, prepared, condensed and filled as viewed in the post-operative radiograph.

Criteria for clinical or contractual Denial of Payment:

III.E.6 Patient was not eligible at the time of service. For root canal therapy that requires multiple stages, the patient must remain eligible continuously from the start to the finish of the root canal.

III.E.7 Procedure is not a covered benefit under the plan or the program.

III.E.8 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.E.9 There is no evidence of need or the treatment of the tooth will not improve/restore function.

III.E.10 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service, including requests for payment for services that are within the scope of services typically provided by general dentists.

III.E.11 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval.

III.E.12 Periodontal disease has destroyed the bone around the tooth.

III.E.13 Inadequate bone support.

III.E.14 The root canal outcome does not meet the standard of care (e.g. poorly accessed, prepared, condensed, perforated and/or filled.) Consideration should be given for reasonable explanations of unusual outcomes.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.

III.E.15 Requirements for submission had not been met (e.g. PCD did not properly refer).

III.E.16 Additional information is needed in order to make a determination.

III.E.17 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.PD <u>Pediatric Dentistry Claims</u>

Provider Requirements for Submission:

III.PD.1 Evidence of need for requested benefits, include, but are not limited to, a diagnosis of decay, fracture, infection or other dental condition with supporting radiographs and/or narrative. The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The provider must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.

Criteria for Approval of Payment:

III.PD.2 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

III.PD.3 There is no age restriction for GMC/LAPHP members.

III.PD.4 In cases where there were no radiographs submitted for preauthorization, consideration of payment is based on the pre-operative radiographs or appropriate photographs taken at the time of treatment. The radiographs submitted should be diagnostic and of acceptable quality.

III.PD.5 Evidence of need for the procedure is evident in the radiographs, photographs or by written documentation.

III.PD.6 In cases where multiple treatment procedures are requested, line-item approval/denial is acceptable. Narrative comments are recommended.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Consideration for Pediatric Dentistry Claims:

III.PD.7 Consider the increased risks associated with sedation.

III.PD.8 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the

control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but not be limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedations may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

III.PD.9 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or when there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical and contractual Denial or Modification of Claim Payment:

III.PD.10 Patient was not eligible at the time of service.
III.PD.11 Procedure is not a covered benefit under the plan or the program.
III.PD.12 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
III.PD.13 The procedure is within the scope and/or responsibility of the PCD (i.e. prophy).
III.PD.14 Consultation fees are not covered when performed on the same day as treatment.
III.PD.15 No evidence of need.
III.PD.16 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.
III.PD.17 Requirements for submission have not been met.
III.PD.18 Additional information is needed in order to make a determination.
III.PD.19 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc..)

III.PR **Periodontic Claims**

Provider Requirements for Submission:

III.PR.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 4 months of the request). The provider must document if and why radiographs cannot be obtained.

III.PR.2 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Most recent periodontal chart must be dated and within 4 months of the pre-authorization request.

III.PR.3 Evaluation including member compliance and prognosis should be present.

Criteria for Approval of Payment:

III.PR.4 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a general practitioner. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene, and/or supplemental therapeutic protocols:
Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces
Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.

III.PR.5 Evidence of need should be supported by proper periodontal charting (dated within 4 months of the preauthorization request), radiographic evidence of bone loss and/or the presence of calculus, or written documentation by the provider. Evidence of need may include, but is not limited to, a diagnosis of periodontal disease as well as narrative and submitted documentation supporting a clinical judgment that surgical intervention will most likely provide for disease control and retention of teeth in question for at least 3 years with little chance for additional surgical intervention during that time period.

III.PR.6 Periodontal consultation may be approved if the PCD needed assistance with treatment planning and sequencing.

Criteria for clinical or contractual Denial or Modification of Claim Payment:

III.PR.7 Patient was not eligible at the time of service.

III.PR.8 Procedure is not a covered benefit under the plan or the program.

III.PR.9 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.PR.10 The procedure is within the scope and/or responsibility of the PCD. Such a procedure will be denied if the claim is submitted by the specialist (e.g. scaling and root planing).

III.PR.11 Poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II ore greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis or need for treatment not established. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

III.PR.12 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.

III.PR.13 Requirements for submission have not been met.

III.PR.14 Additional information is needed in order to make a determination.

III.PR.15 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use with associated poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.R **<u>Restorative Dentistry Claims</u> (including filling restorations, crowns, bridges, implant-supported restorations and removable prosthetics)**

Provider Requirements for Submission:

III.R.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The provider must document if and why radiographs cannot be obtained. When full mouth radiographs are not available, a sufficient number of radiographs (tooth in question, opposing arch, and contra-lateral views) and appropriate views (periapical, bitewing and/or panoramic radiographs) to justify the proposed treatment must be submitted.

III.R.2 Diagnostic copies or original radiographs are acceptable.

III.R.3 Evaluation by the PCD: including member compliance, overall prognosis (perio and endo) and the amount of available tooth structure should be documented for such procedures as crown, bridges, and removable partial dentures. Evidence of history of poor oral hygiene, poor member self-care may result in denial.

Criteria for clinical or contractual Denial or Modification of Payment:

III.R.4 Patient was not eligible at the time of service. For crowns, veneers, bridges, and prosthetics, the patient must be eligible continuously from the starting date to the finishing date.

III.R.5 Procedure is not a covered benefit under the plan or the program.

III.R.6 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.R.7 There is no documentation of evidence of need. Evidence of need may include, but is not limited to, radiographs, written narrative documentation, photos, and/or models supporting a diagnosis of decay, fracture, infection or other condition.

III.R.8 There was a more conservative treatment option within the professional standard of care (e.g. filling vs. crown, filling vs. prophylactic pulpotomy, etc.).

III.R.9 There exists an infection that must be treated, or a procedure is requested when another procedure is required prior to the requested procedure for the optimal outcome, (i.e. treatment is not consistent with the optimal treatment sequence).

III.R.10 The tooth or implant did/would not have the adequate bone support and/or tooth structure for a favorable outcome.

III.R.11 The restoration did not improve/restore function. There is a lack of an opposing tooth, adequate arch integrity or adequate occlusion.

III.R.12 The final restoration may be denied if a previously completed RCT is unsatisfactory, unstable, and/or symptomatic (e.g. incomplete, short fill, overfill, silver points, Sargenti paste, etc.).

III.R.13 Removable prosthesis or restoration/placement of implants may be denied due to physical limitations, systemic involvement, or emotional disturbances.

III.R.14 Adequate space is required for approval of replacement of tooth/teeth or restoration/placement of implants.

III.R.15 Procedure is not indicated in a primary tooth because the primary tooth will be replaced in the arch (e.g. laboratory fabricated crowns).

III.R.16 Replacement teeth may be denied when there are 1) adequate teeth in the arch to support existing teeth for proper mastication (biting and chewing) and function and to prevent tooth movement or shifting (e.g. replacement of long-standing missing teeth in a stable occlusion), or 2) Removable Partial Dentures or implants to replace 2nd and 3rd molars where there are no functional opposing teeth.

III.R.17 Benefits may be available only for the most inclusive procedure when covered by the plan.

III.R.18 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

III.R.19 When there is more than one restorative procedure that could adequately address the dental condition requiring treatment, the procedure may be recoded to the least-expensive acceptable service covered by the plan.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: PCDs may resubmit Claims with additional materials for review as a new request.

III.R.20 PCD requirements for submission have not been met.

III.R.21 Additional information is needed in order to make a determination.

III.R.22 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION IV – UTILIZATION MANAGEMENT	
IV.C-Disclosure of UM Processes Upon Request	
UMC Chair:	Approved on:
QIC Chair:	Approved on:

IV.C1 – POLICY

It is the policy of Western Dental Services, Inc., ("WDS") to disclose upon request the process and criteria by which it reviews and approves, modifies, delays, or denies requests by providers to enrollees (and/or their authorized representatives), providers and the public.

Utilization Guidelines sent in response to such requests shall include the following notice, as required by the California Health and Safety Code:

> "The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."
> [**CA Health and Safety Code 1363.5(c)**]

IV.C2 - ACCESS TO AUTHORIZATION PROCESS

I. Procedures for Enrollee Access to the Authorization Process

The enrollee or an authorized representative may request a copy of the process and criteria used by WDS to review and approve, modify, delay, or deny requests for services authorization, through written or verbal communication with WDS Referral/Claims Department. WDS Referral/Claims Department shall send to the enrollee WDS Utilization Management Guidelines and/or WDS Utilization Management Policies Section IV.C Disclosure of UM Processes Upon Request, Section IV.D UM Decision Timeframes, and Section IV.E UM Communication Requirements within seven days of receipt of the request. Enrollees are informed of access to the WDS authorization process at least annually.

II. Procedures for Providers Access to the Authorization Process

Providers may request a copy of the process and criteria used by WDS to review and approve, modify, delay, or deny requests for services authorization, through written or verbal communication with the WDS Referral/Claims Department. WDS Referral/Claims Department shall send to the provider WDS Utilization Management Guidelines and/or WDS Utilization Management Policies Section IV.C UM Disclosure of UM Processes Upon Request, Section IV.D UM Decision Timeframes, and Section IV.E UM Communication Requirements within seven days of receipt of the request. Providers shall be informed of this process initially upon contracting with WDS and at least annually, thereafter.

III. Procedures for Public Access to the Authorization Process

Members of the public may request a copy of the process and criteria used by WDS to review and approve, modify, delay, or deny requests for services authorization, through written or verbal communication with the WDS Referral/Claims Department. WDS Referral/Claims Department shall send to the requesting party WDS Utilization Management Guidelines and/or WDS Utilization Management Policies Section

IVC-UM Disclosure of UM Processes Upon Request, Section IV.D UM Decision Timeframes, and Section IV.E UM Communication Requirements within seven days of receipt of the request.

IV.C2 - SCOPE

This policy applies to all WDS enrollees, WDS Staff Model Offices, individual Primary Care Dentists and Specialists and the general public.

VII.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

The following section contains important information on how to coordinate benefit coverage for a WDS member that is also a dependent of another dental plan.

COORDINATION OF BENEFITS
Rules & General Information

In instances where WDS members have benefit coverage through their spouse or parent in addition to their WDS dental coverage please refer to the information below to assist you in coordinating benefits.

In general, the main objective for coordination of benefits is to reduce out of pocket expense to the member.

Benefit Rules

Adults

Patient may be covered as an employee by his/her employer and is a dependent by his/her spouse's employer. The plan that covers the patient as an active employee (the policyholder) has primary responsibility for reimbursement. The benefits of a program, which covers a person as an active employee, are determined before those of a program, which covers a person as a laid-off or retired employee.

Children

If a child is covered as a dependent under both parents' coverage (and parents are not separated or divorced), the plan of the parent with the earliest birthday in the year has primary responsibility for payment in most states.

If a child of divorced or separated parents is covered as a dependent under the parent's coverage, benefits are determine in this order:

1. The program of the parent who has custody of the child.
2. The program of the spouse of the parent who has custody of the child.
3. The program of the parent not having custody of the child.

General Information

- If spouses/dependents are covered by the Company and another managed care program; the Provider will be receiving monthly payments from both programs. Therefore, the doctor must accept the coverage that best benefits the patient.
- If none of the above rules determine the order of benefits, the plan which has covered the employee the longest has primary responsibility for payment.
- If a patient has a conversion plan with the Company, and then obtains dental coverage through a new employer, the group is billed as if there were no other coverage. The conversion plan is not subject to COB.

Billing Information

To minimize confusion on the part of the insurance carrier, we recommend your office bill out its full usual and customary fees (UCR). This allows the other carrier to determine the appropriate payment based upon their specific benefit level.

If the other coverage is a group insurance program the provider may use his usual and customary fees for submitting insurance claims, but he may not collect more, from the combined insurance payments and the member payments, than the copayments specified in the program of benefits. If spouses/dependents are covered by the Company and another managed care program; the Provider will be receiving monthly payments from both programs. Therefore, the doctor must accept the coverage that best benefits the patient.

The provider may however, accept any insurance payment more than the copayment for a specified covered service, if there is no member payment.

In most instances, the Western Dental Member would not be charged his/her copayment, as the insurance payment would cover this liability. In the rare instance where the insurance payment is not equal to the co-payment, the office may charge the member the difference between the two. If the professional provider is a participating dentist for both prepaid plans, then charge the lesser of the two plan's co-payments applicable to the services rendered.

EXAMPLE:

Service	*HMO*	*UCR*	*Indem*	*Pt. Pays*	*Credit*
Prophylaxis	$ 0.00	$ 35.00	$ 35.00	$ 0.00	$ 0.00
Office Visit	$ 0.00	$ 20.00	$ 20.00	$ 0.00	$ 0.00
Total	**$ 0.00**	**$ 55.00**	**$ 55.00**	**$ 0.00**	**$ 0.00**

The Dental Office may retain the $55.00 paid by the indemnity carrier.

EXAMPLE:

1 Sur Amal	$ 25.00	$ 40.00	$ 32.00	$ 0.00	$ 7.00
PFM Crown	$250.00	$550.00	$275.00	$ 0.00	$ 25.00
Total	**$275.00**	**$590.00**	**$307.00**	**$ 0.00**	**$ 32.00**

The Dental Office applies the credit of $32.00 paid by the indemnity carrier to the Members future dental treatment.

VIII.

SPECIALTY SERVICES

SPECIALTY SERVICES

The following section contains important information about how to refer patients to specialists as well as information about the guidelines or criteria that are utilized by WDS for Utilization Review decicions.

REFERRAL SYSTEM PROTOCOL

The following pages outline the Referral System Protocol implemented at Western Dental Services, Inc., ("WDS"). The intent is to assure that specialty referrals are handled timely without delays for the provider or for the member. WDS is committed to providing quality managed care to all members with the interest of comfort and health as a priority.

WDS shall ensure a process by which review decisions are based on the medical necessity of the proposed dental health care services and are consistent with criteria or guidelines that are supported by sound clinical principles and processes.

Please review the protocol and the "UM Guidelines or Criteria" with the members of your staff. If you have any questions or concerns about the process, please contact our Specialty Referral Department at **1-800-992-3366.**

Referral Benefit/Prior Authorization Requirement

Under the WDS program, referral to a specialist (Endodontist, Oral Surgeon, Orthodontist, Pedodontist or Periodontist) is a covered benefit at no additional cost to you or your office with no reduction in your capitation fees (providing that the guidelines within this guide are followed). Please refer to the Plan Benefits section for specific coverage. Prior authorization is required. All specialty referrals MUST be pre-approved by WDS before the patient referral is made.

How to Complete a Specialty Referral Request

The WDS contracted general dentist requests a specialty referral by submitting a WDS Referral form *(see attached copy).*

If you would like to request additional referral forms please contact the WDS Member Services Department at **1-800-992-3366.**

1. In the upper right side of the form, identify the type of specialty desired by checking the applicable box under "Referral For:"
2. Complete the provider and patient identification information.
3. Identify the tooth number or quadrant, description of service and applicable procedure code.
   Please do not enter the specialist's name. WDS will complete this section.
4. Mail first four copies of the **"Specialty Referral Form"** to:

   Western Dental Services, Inc.
   P.O. Box 14227
   Orange, CA 92863
   Attention: Specialty Referral Department

Be sure to include radiographs, pocket depth charting (for referrals to a Periodontist), and your clinical evaluation with reason for referral. Advise the member that they will receive notification from WDS in the timeframes specified below. Please allow time for mail service.

How to Complete an Emergency Referral Request

Emergency Dental Care means services to diagnose and treat a dental condition, which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person with no special knowledge of dentistry could not reasonably expect the absence of immediate dental attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health ofthe woman or her unborn child) in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

To refer a patient for timely treatment in an emergency situation, the following steps must be taken:

1. Telephone Western Dental Services (WDS) at 1-800-992-3366 and inform the representative of the emergency while the patient is in the office (if applicable).
2. Verbal approval may be given based on the nature of the emergency. If approved, WDS will complete the referral request form, and refer the patient to a specialist. Retrospective review of the patient's pre-operative and post-operative x-rays will be conducted by a WDS Dental Consultant. In the event the Dental Consultant determines that this procedure did not meet the referral guidelines and could have been performed in a general dentistry setting, the referring office could be held financially responsible for the cost of the specialist's services minus the patient's copayment.

When calling WDS for emergency approval, please have the following information available:

1. Your provider number
2. The member's social security number or WDS member identification number.
3. Your diagnosis and applicable ADA/CDT code. Your reason for the emergency referral, including the member's medical condition.
4. The type of specialist required
5. The tooth number
6. Date of submission, if a referral has already been submitted for the same treatment
7. WDS will also need to know the following information for endodontic referrals.
   - Type of pain relief your office administered to patient. For example: open and medicate, incise and drain or medications.
   - Was there an attempt to negotiate canals for calcified canals?
   - If you are requesting a root canal re-treatment, when and by who was the original root canal therapy completed?
8. Emergency oral surgery referrals will be approved for symptomatic extractions only. Please provide diagnostic quality x-rays to the patient to hand carry to their appointment with the oral surgeon.

Specialty Care Guidelines for Plan Providers

Please consult the benefits section for detailed coverage information and procedures. In cases where the plan pays part or all of the specialty fees, specific approvals must be obtained from WDS.

WDS does not wish to dictate any course of treatment. We expect our providers to deal with each case according to their own moral, ethical and technical guidelines. Whatever rationale of treatment is utilized, it must be compatible with accepted professional standards.

It is the responsibility of the general practitioner to perform all dental procedures that are within the scope of general dentistry. Please refer to the WDS **"IV.B-UM Guidelines or Criteria"** in the "Utilization Management Policies and Procedures" section for detailed information about true criteria or guidelines used in making utilization review decisions. Procedures that are not within the scope of a general practitioner may include, but are not limited to the following:

ORAL SURGERY

1. Removal of teeth that are complete bony impactions;
2. Removal of teeth that are partial bony impactions;
3. Treatment of cysts and neoplasms;
4. Extractions of teeth in close proximity or connecting to the maxillary sinus;
5. Extractions of teeth in close proximity or connecting to the mandibular canal;
6. Difficult surgical extractions (badly broken down, old root canal therapy);
7. Frenectomies;
8. Treatment of complications requiring unusual post-operative care where detailed written explanations are provided by the oral surgeon.

General dentists are expected to perform all simple and/or surgical extractions unless the patient's conditions are as noted above.

ENDODONTICS

It is expected that the primary care provider render single and multiple canal endodontic treatment. WDS expects all participating providers to perform standard endodontic therapy and palliative procedures on any tooth requiring such therapy, including all molars, with the exception of the following:

1. Re-treatments;
2. Treatment of teeth with extreme curvature of canals;
3. Treatment of teeth with calcified (blocked) canals with documented attempt made;
4. Apicoectomies;
5. Dilacerated (flared out) roots;
6. Treatment of teeth associated with oral pathology, large cysts or abscesses.

Coverage for endodontic therapy at a specialist can only be approved by a WDS Dental Consultant upon review of the required documentation, including the radiograph. Therefore, emergency referral benefits approved over the telephone are subject to retrospective review for compliance with WDS referral guidelines. In the event the Dental Consultant determines that this procedure did not meet the referral guidelines and could have been performed in a general dentistry setting, the referring office could be held financially responsible for the cost of the specialist's services minus the patient's copayment. WDS expects the panel office to provide satisfactory palliative treatment to the member prior to requesting the referral, whenever necessary. Palliative treatment should be rendered even if the necessary definitive treatment is beyond the scope of the general practitioner. This emergency treatment may include but not be limited to the following:

- Pulpotomy
- Incision and drain
- Occlusal adjustment
- Prescription for antibiotics
- Prescription for analgesics

PERIODONTICS

It is the responsibility of the general practitioner to perform all dental procedures that are within the scope of general dentistry. Procedures that are not within the scope of a general practitioner may include, but are not limited to the following:

1. Gingivectomy or Gingivoplasty, per tooth (less than six teeth).
2. Gingivectomy or Gingivoplasty, per quadrant.
3. Osseous and Mucogingival surgery, per quadrant.

Requests for referral for periodontal care must include the following:

1. Full-mouth periapical and bitewing radiographs;
2. Initial full-mouth periodontal charting (prior to scaling and root planing);
3. Post-scaling and root planing periodontal charting;
4. Dates that scaling and root planing and any periodontal maintenance were performed.

ORTHODONTIA

If the member requires orthodontia, please contact WDS at **1-800-992-3366** for the name, phone number and address of a local Orthodontic WDS provider or refer to the online provider directory at http://www.westerndentalbenefits.com.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION IV – UTILIZATION MANAGEMENT	
IV.B-UM Guidelines or Criteria	
UMC Chair:	Approved on:
QIC Chair:	Approved on:

IV.B1 - UTILIZATION MANAGEMENT GUIDELINES POLICY

It is the policy of Western Dental Services, Inc., ("WDS"), to ensure that when Utilization Review decisions are based in whole or in part on the medical necessity of the proposed dental health care services, that any such Utilization Review decisions are consistent with criteria or guidelines that are supported by sound clinical principles and processes.

The Quality Improvement Committee ("QIC") oversees and approves the development of, and the updates to, the Utilization Management Guidelines. The Utilization Management Committee, by way of a Utilization Management Guidelines Subcommittee, whose membership includes general dental and specialty providers participating in the network, develops and, at least annually, reviews and updates, whenever necessary, the criteria and guidelines for making dentally appropriate decisions that are consistent with accepted professional standards of care, such as the Clinical Guidelines of the American Academy of Pediatric Dentistry, the Parameters of Care of the American Academy of Periodontology, the Selection of Patients for X-ray Examinations: Dental Radiographic Examinations by the U.S. Department of Health and Human Services, and the Guidelines and Position Statements of the American Association of Endodontists. These guidelines shall take into account the health, age, tolerance of physical and emotional stress of the member, as well as the medical necessity and appropriateness of the treatment, with evidence of need. Treatment should result in acceptable quality of care and acceptable, predictable treatment outcomes.

These guidelines may be superseded by plan-specific coverage guidelines.

IV.B2 - UTILIZATION MANAGEMENT GUIDELINES

WDS Utilization Management Guidelines are attached hereto.

IV.B3 - SCOPE

The scope of the UM Program and its policies shall include WDS Staff Model Offices, individual Primary Care Dentists (PCD) and Specialists.

WESTERN DENTAL SERVICES, INC.
UTILIZATION MANAGEMENT REVIEW GUIDELINES

It is the policy of Western Dental Services, Inc., ("WDS"), that a qualified licensed dentist shall supervise the review of all decisions related to requests for authorization of health care services for a member. All decisions to deny, modify or defer a request for authorization ("prospective review") or requests for payment for health care services ("retrospective review") based in whole or in part on medical necessity must be made by a qualified licensed dentist.

Any reviews must take into consideration sufficient documentation and evidence to confirm the need for the requested or provided health care services. Treatment should result in acceptable quality of care and acceptable, predictable treatment outcomes. The requested procedure must be a covered benefit of the program/plan.

Unless otherwise stated in benefit plan documents, the following guidelines are used by WDS for utilization management decisions based in whole or in part on medical necessity.

I. GUIDELINES FOR AUTHORIZATIONS FOR REFERRALS

The following Utilization Review guidelines apply for Requests for Referral benefits for procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits.

I.OS **Oral Surgery Referrals**
Provider Requirements for Submission:

Third Molar Extractions:

I. OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

I. OS.2 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

I. OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the proper eruption or restoration of the adjacent second molar or causes potential damage to the second molar.

I. OS.4. The PCD should document for each individual tooth the evidence of need for the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

I. OS.5 The age and the health of the member and the member's current dental condition should be carefully considered (e.g. removal of asymptomatic 3rd molar extractions may not be recommended for members over the age of 26 years without evidence of pathology or symptoms that cannot be treated in another fashion due to the increased risk of complications such as ankylosis and jaw fracture).

I. OS.6 Alternative treatments (including no treatment), benefits and risks to the member with regards to the extraction of the 3rd molar, should be considered.

I.OS.7 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment, and benefits for treatment that meet the benefit criteria should be approved with the referral. However, this is within the discretion of the dentist reviewer.

Non-Third Molar Extractions and Other Covered Surgical Procedures:

I. OS.8 There must be adequate quantity and quality of radiographs, photographs, other images, etc. to support the diagnosis and classification of the procedure.

I. OS.9 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

I. OS.10 The condition of the tooth or the surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

I. OS.11 Alternative treatments (including no treatment), benefits and risks to the member with regards to the procedure(s) should be considered.

Criteria for Approval of Benefits:

I.OS.12 Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a general practitioner. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.); surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided by a general dentist.

I.OS.13 For members who are not edentulous, referrals for implant consultation must include a full series of radiographs and a comprehensive restorative treatment plan for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

I.OS.14 For members who are not edentulous, referrals for implant placement must include a full series of radiographs, a comprehensive restorative treatment plan, and a notation designating the intended restorative facility - the referring restorative office or another contracting WDS office - for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

General Anesthesia and Sedation Considerations for Oral Surgery Referrals:

I.OS.15 Consider the increased risks associated with general anesthesia and sedation.

I.OS.16 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of pain/anxiety control.

f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

I.OS.17 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. To alleviate member apprehension, nervousness, fear, or behavior management (except for pediatric members or physically compromised or mentally challenged adult members, as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits or Modification of procedure:

I.OS.18 Patient is no longer eligible or a member.
I.OS.19 Procedure is not a covered benefit under the plan or the program.
I.OS.20 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
I.OS.21 There is no submitted evidence of need.
I.OS.22 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for referral benefits for those services that are within the scope of services typically provided by general dentists.
I.OS.23 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits due to insufficient submitted materials to meet the requirements for benefit determination:

NOTE: Providers may resubmit the Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.OS.24 PCD requirements for submission have not been met.
I.OS.25 Additional information is needed in order to make a determination.
I.OS.26 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document the tooth number and/or service requested, or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, history of BRONJ, IV bisphosphonate usage, xerostomia, radiation exposure, etc.))

I.E **Endodontic Referrals**

Provider Requirements for Submission:

I.E.1 The PCD must submit a diagnostic PA of the tooth or area of concern (as well as a bitewing for posterior teeth) and mounted (with the left and right sides distinguished) and dated additional radiographs to establish integrity of the arch, the strategic value of retaining the tooth, and its contribution to the dentition as a whole. The referral will be denied for incomplete submission if the radiographic documentation is incomplete, unless

it is an emergency requiring treatment within 72 hours and the non-radiographic documentation adequately supports approval of the referral.

I.E.2 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment, and benefits for treatment that meet the benefit criteria should be approved with the referral. However, this is within the discretion of the dentist reviewer.

I.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth, with no indication of reasonable plans for replacement of the opposing tooth). The submitting provider may be asked to submit supplemental narrative documentation whenever possible to establish need for the requested procedure(s).

I.E.3.b Benefits are not available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable furcal or inter-proximal involvement, excessive mobility or inadequate bone support.

I.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, unfavorable crown-to-root ratio with advanced bone loss.

I.E.4 Cases with no radiographic and/or documented evidence of need for treatment will result in a denial. Evidence of need may include, but is not limited to, diagnosis of extensive caries affecting the pulp, periapical pathology or symptoms indicating the existence of infection due to degeneration of the pulp, or irreversible pulpitis of the tooth.

I.E.5 If the tooth has a perio-endo lesion, then a periodontal consultation should be done prior to the completion of the endodontic procedure to ensure that the tooth has a reasonable prognosis. The periodontal consultation is necessary to determine and document whether the treatment can result in a predictable, successful outcome. However, when necessary, pain relief should be provided to the member by the PCD or, in difficult cases, by the endodontist prior to the periodontal referral, including but not limited to prescribing pain medication, occlusal adjustment, extirpation of a portion or all of the pulp, placement of a temporary restoration, extraction (in some cases), etc.

I.E.6 Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial. The PCD can submit written documentation with regards to the member's compliance with oral hygiene and compliance with seeking regular dental treatment.

I.E.7 The endodontic services that are within the scope of services typically performed by PCDs include diagnostic procedures performed to establish the need for endodontic treatment, RCTs on all anterior teeth, bicuspids and most molars, unless documentation provided by the PCD suggests otherwise. WDS considers the performance of pulp testing to be included in the covered examination.

Criteria for Approval of Benefits:

I.E.8 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but not be limited to the following: additional covered diagnostics necessary to establish need for the requested procedure, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots

(dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, treatment of canal obstructions and/or hemisections.

Criteria for clinical or contractual Denial of Benefits:

I.E.9 Patient is no longer eligible or a member.
I.E.10 Procedure is not a covered benefit under the plan or the program.
I.E.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
I.E.12 There is no evidence of need or the treatment of the tooth will not improve/restore function.
I.E.13 The information submitted by the PCD about the member's current dental condition does not meet the minimum requirement for approval of the service.
I.E.14 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval. WDS does not generally provide benefit for endodontic treatment for teeth requiring hemisection or root amputation.
I.E.15 Root fracture or continuous vertical coronal fracture that is subosseous.
I.E.16 Periodontal disease has destroyed the bone around the tooth.
I.E.17 Inadequate bone support.
I.E.18 The procedure is determined to be within the scope and/or responsibility of the PCD.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: PCDs may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.E.19 PCD requirements for submission have not been met.
I.E.20 Additional information is needed in order to make a determination.
I.E.21 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

I.PD **Pediatric Dentistry Referrals**

Provider Requirements for Submission:

I.PD.1 The PCD must submit mounted (with the left and right sides distinguished) and dated full mouth radiographs. The radiographs submitted should be diagnostic and of acceptable quality. The PCD must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.
I.PD.2 The provider must document why treatment of the member is not within the scope of the provider. In cases where the member is uncooperative, the provider must document the dates of any unsuccessful attempts to treat the member.

Criteria for Approval of Benefits:

I.PD.3 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

I.PD.4 There is no age restriction for GMC/LAPHP members.

I.PD.5 In cases where there are no radiographs submitted with the request for referral benefits, consideration of authorization/payment will be based on the pre-operative radiographs or appropriate photographs taken at the pediatric dental office.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Considerations for Pediatric Dentistry Referrals:

I.PD.6 Consider the increased risks associated with sedation.

I.PD.7 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. The definition of "prolonged" (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

I.PD.8 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits:

I.PD.9 Patient is no longer eligible or a member.

I.PD.10 Procedure is not a covered benefit under the plan or the program.

I.PD.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

I.PD.11 The procedure is within the scope and/or responsibility of the PCD (e.g. prophy).

Criteria for Denial of Benefits Request due to insufficient submitted materials:
NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.PD.12 PCD requirements for submission have not been met.

I.PD.13 Additional information is needed in order to make a determination.

I.PD.14 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information such as incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc.).

I.PR **Periodontal Referrals**

Provider Requirements for Submission:

I.PR.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 12 months of the request). The provider must document if and why radiographs cannot be obtained.

I.PR.2 The PCD must document why treatment of the member is not within the scope of the PCD (e.g. surgical case, medically compromising conditions, etc.).

I.PR.3 The member should have had pre-treatment pocket charting, timely scaling and root planing (SRP) and a post-treatment re-evaluation. Pocket charting should be recorded at the re-evaluation. In addition, the member must have had at least one periodontal maintenance visit (usually 3-4 months after scaling and root planing) by the PCD within 4 months of the referral request, with recording of pocket charting, prior to referral to the periodontist for surgical treatment of periodontal disease.

I.PR.4 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Periodontal chart must be dated.

I.PR.5 A periodontist may be consulted to assist the PCD with treatment planning.

I.PR.6 Evaluation by the PCD, including member compliance and prognosis, should be present.

Criteria for Approval of benefits:

I.PR.7 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for the treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection, or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene and/or other supplemental therapeutic protocol:
Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces
Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.

I.PR.8 Evidence of need should be supported by proper periodontal charting, radiographic evidence of bone loss and the presence of calculus, and, when necessary, written documentation by the PCD. An adequate level of home care and oral hygiene must be documented. The PCD must submit the following documentation for approval of specialty treatments: 1) pocket charting from the initial examination, the periodontal re-evaluation, when available, and the periodontal maintenance visit.

I.PR.9 A periodontal consultation may be approved if the PCD needs assistance with treatment planning and sequencing.

Criteria for clinical and contractual Denial of Benefits:

I.PR.10 Patient is no longer eligible or a member.

I.PR.11 Procedure is not a covered benefit under the plan or the program.

I.PR.12 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

I.PR.13 The procedure is within the scope and/or responsibility of the PCD (e.g. scaling and root planing).

I.PR.14 Poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II or greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis or need for referral not established. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

I.PR.15 PCD requirements for submission have not been met.

I.PR.16 Additional information is needed in order to make a determination.

I.PR.17 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information when needed by the reviewer to establish need for the procedure or reasonable prognosis, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factor, xerostomia, radiation exposure, etc.).

II. GUIDELINES FOR REVIEW OF PRE-AUTHORIZATIONS

The following Utilization Review guidelines apply for requests for Pre-Authorization of benefits for procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits.

II.OS **Oral Surgery Pre-Authorizations**
Provider Requirements for Submission:

Third Molar Extractions:

II. OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

II. OS.2 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

II. OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the proper eruption or restoration of the adjacent second molar or causes potential damage to the second molar.

II. OS.4. The provider should document for each individual tooth the evidence of need for the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

II. OS.5 The age and the health of the member and the member's current dental condition should be carefully considered (e.g. removal of asymptomatic 3rd molar extractions may not be recommended for members over the age of 26 years without evidence of pathology or symptoms that cannot be treated in another fashion due to the increased risk of complications such as ankylosis and jaw fracture).

II. OS.6 The condition of the tooth and the surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

II. OS.7 Alternative treatments (including no treatment), benefits and risks to the member with regards to the extraction of the 3rd molar should be considered.

Non-Third Molar Extractions and Other Covered Surgical Procedures:

II. OS.8 There must be adequate quantity and quality of radiographs to support the diagnosis and classification.

II. OS.9 Should appropriate clinical need for the extractions(s) or surgery not be radiographically evident, written, photographic or other imaging justification of the need for treatment must be provided.

II. OS.10 The condition of the tooth or surrounding anatomical features should be considered to avoid unnecessary complications (e.g. sinus perforation, paresthesia, broken jaw, etc.).

II. OS.11 Alternative treatments (including no treatment), benefits and risks to the member with regards to the procedure(s) should be considered.

II.OS.12 For members who are not edentulous, requests for benefits for implant placement must include a full series of radiographs, a comprehensive restorative treatment plan, and a notation designating the intended restorative facility - the referring restorative office or another contracting WDS office - for benefits to be approved. (A panoramic radiograph or CT scan should also be provided, if available). For members who are edentulous, a panoramic radiograph or CT scan may be substituted for the full series of radiographs.

Criteria for Approval of Benefits:

II.OS.13 Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a general practitioner. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.);

surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided a general dentist.

General Anesthesia and Sedation Considerations for Oral Surgery Pre-Authorizations:

II.OS.14 Consider the increased risks associated with general anesthesia and sedation.

II.OS.15 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of pain/anxiety control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

II.OS.16 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. To alleviate member apprehension, nervousness, fear, or behavior management (except for pediatric members or physically compromised or other mentally challenged adult members, as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial of Benefits or Modification of procedure:

II.OS.17 Patient is no longer eligible or a member.

II.OS.18 Procedure is not a covered benefit under the plan or the program.

II.OS.19 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.OS.20 There is no submitted evidence of need.

II.OS.21 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for pre-authorization of services that are within the scope of services typically provided by general dentists.

II.OS.22 Procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request: Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.OS.23 PCD requirements for submission have not been met.

II.OS.24 Additional information is needed in order to make a determination.

II.OS.25 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, history of BRONJ, IV bisphosphonate usage, xerostomia, radiation exposure, etc.)

II.E Endodontic Pre-Authorizations

Provider Requirements for Submission:

II.E.1 The provider must submit a diagnostic PA of the tooth (as well as a bitewing for posterior teeth) and mounted (with the left and right sides distinguished) and dated additional radiographs to establish integrity of the arch, the strategic value of retaining the tooth, and its contribution to the dentition as a whole. The pre-authorization will be denied for incomplete submission if the radiographic documentation is incomplete, unless it is an emergency requiring treatment within 72 hours and the non-radiographic documentation supports approval of the pre-authorization.

II.E.2 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment and benefits for treatment that meet the benefit criteria should be approved. However, this is within the discretion of the Dental Consultant reviewer.

II.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth). The provider may be asked to submit supplemental narrative documentation whenever possible to establish need for the requested procedure(s).

II.E.3.b Benefits are not available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable inter-proximal or furcal involvement, excessive mobility or inadequate bone support.

II.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, unfavorable crown-to-root ratio with advanced bone loss.

II.E.4 Cases with no radiographic and/or documented evidence of need for treatment will result in a denial. Evidence of need may include, but is not limited to, diagnosis of extensive caries affecting the pulp, periapical pathology or symptoms indicating the existence of infection due to degeneration of the pulp, or irreversible pulpitis of the tooth.

II.E.5 If the tooth has a perio-endo lesion, then a periodontal consultation should be done prior to the completion of the endodontic procedure to ensure that the tooth has a reasonable prognosis. The periodontal consultation is necessary to determine and document whether the treatment can result in a predictable, successful outcome. However, when necessary, pain relief should be provided to the member by the PCD or, in difficult cases, by the

endodontist prior to the periodontal referral, including but not limited to prescribing pain medication, occlusal adjustment, extirpation of a portion or all of the pulp, temporary restoration, etc.

II.E.6 Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial.
The provider can submit written documentation with regards to the member's compliance with oral hygiene and compliance with seeking regular dental treatment. II.E.7 The endodontic services that are within the scope of services typically performed by PCDs include diagnostic procedures performed to establish the need for endodontic treatment. RCTs on all anterior teeth, bicuspids, and most molars, unless documentation provided by the PCD suggests otherwise. WDS considers the performance of pulp testing to be included in the covered examination.

Criteria for Approval of Benefits:

II.E.8 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but not be limited to the following: additional covered diagnostics necessary to establish the need for the procedure, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots (dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, treatment of canal obstructions and/or hemisections. Any available diagnostics performed by the referring PCD should be provided to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Benefits for treatment of obstruction are considered inclusive in the global procedure for root canal therapy for instances of endodontic re-treatments, calcified canals and other calcifications such as pulp stones. Benefits for the removal of existing posts, pins and build-ups are considered to be inclusive in the procedure for endodontic re-treatment. However, at the discretion of the dentist reviewer, benefits may be available for other obstructions such as separated instruments, etc. The use of specialized materials (e.g. MTA, MTAD, etc.) is generally considered to be included in the procedure. No additional benefit is provided for specialized materials.

Criteria for clinical or contractual Denial of Benefits:

II.E.9 Patient is no longer eligible or a member.

II.E.10 Procedure is not a covered benefit under the plan or the program.

II.E.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.E.12 There is no evidence of need or the treatment of the tooth will not improve/restore function.

II.E.13 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service.

II.E.14 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval. WDS does not generally provide benefit for endodontic treatment for teeth requiring hemisection or root amputation.

II.E.15 Root fracture or continuous vertical coronal fracture subosseous.

II.E.16 Periodontal disease has destroyed the bone around the tooth.

II.E.17 Inadequate bone support.

II.E.18 The procedure is determined to be within the scope and/or responsibility of the PCD.

Criteria for Denial of Benefits Request due to insufficient submitted materials:
NOTE: Providers may resubmit Request for Referral with additional materials for review as a new Request: Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.E.19 Requirements for submission have not been met.

II.E.20 Additional information is needed in order to make a determination.

II.E.21 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect/wrong tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of a significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

II.PD Pediatric Dentistry Pre-Authorizations

Provider Requirements for Submission:

II.PD.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full mouth radiographs. The radiographs submitted should be diagnostic and of acceptable quality. The provider must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.

II.PD.2 Evidence of need for requested benefits, include, but are not limited to, a diagnosis of decay, fracture, infection or other dental condition with supporting radiographs and/or narrative.

Criteria for Approval of Benefits:

II.PD.3 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

II.PD.4 There is no age restriction for GMC/LAPHP members.

II.PD.5 In cases where there are no radiographs submitted with the request for pre-authorization, consideration of authorization/payment will be based on the pre-operative radiographs and/or appropriate photographs taken at the time of treatment. The radiographs submitted should be diagnostic and of acceptable quality.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Considerations for Pediatric Dentistry Pre-Authorizations:

II.PD.6 Consider the increased risks associated with sedation.

II.PD.7 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but are not limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.

b. Spastic-type handicapping condition.

c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

II.PD.8 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or when there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial or Modification of Benefits:

II.PD.9 Patient is no longer eligible or a member.
II.PD.10 Procedure is not a covered benefit under the plan or the program.
II.PD.11 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
II.PD.12 Insufficient evidence of need or the procedure is within the scope and/or responsibility of the PCD (e.g. prophy).
II.PD.13 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.PD.14 PCD requirements for submission have not been met.
II.PD.15 Additional information is needed in order to make a determination.
II.PD.16 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc.).

II.PR <u>Periodontal Pre-Authorizations</u>

Provider Requirements for Submission:

II.PR.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 12 months of the request). The provider must document if and why radiographs cannot be obtained.
II.PR.2 If not obvious, the provider must document why treatment of the member is not within the scope of the PCD (e.g. surgical case, medically compromised, etc.).

II.PR.3 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Most recent periodontal chart must be dated and within 4 months of the pre-authorization request.

II.PR.4 Evaluation, including member compliance and prognosis, should be present.

Criteria for Approval of Benefits:

II.PR.5 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a PCD. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene, and/or supplemental therapeutic protocols:

Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces

Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.II.PR.6

Evidence of need should be supported by proper periodontal charting (dated within 4 months of the preauthorization request), radiographic evidence of bone loss and/or the presence of calculus, or written documentation by the provider. Evidence of need may include, but is not limited to, a diagnosis of periodontal disease as well as narrative and submitted documentation supporting a clinical judgment that surgical intervention will most likely provide for disease control and retention of teeth in question for at least 3 years with little chance for additional surgical intervention during that time period.

Criteria for clinical and contractual Denial or Modification of Benefits:

II.PR.7 Patient is no longer eligible or a member.

II.PR.8 Procedure is not a covered benefit under the plan or the program.

II.PR.9 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

II.PR.10 The procedure is within the scope and/or responsibility of the PCD (e.g. scaling and root planing), evidence of need is not demonstrated for the procedure, there is a poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II or greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

II.PR.11 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.PR.12 Requirements for submission have not been met including the appropriate provision of initial pre-surgical therapy by the PCD.

II.PR.13 Additional information is needed in order to make a determination.

II.PR.14 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or

supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

II.R **<u>Restorative Dentistry Pre-Authorizations</u> (including filling restorations, crowns, bridges, implant-supported restorations and removable prosthetics)**

Provider Requirements for Submission:

II.R.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs. The provider must document if and why radiographs cannot be obtained. When full mouth radiographs are not available, a sufficient number of radiographs (tooth in question, opposing arch, and contralateral views) and appropriate views (periapical, bitewing and/or panoramic radiographs) to justify the proposed treatment must be submitted.

II.R.2 Diagnostic copies or original radiographs are acceptable.

II.R.3 Evaluation by the PCD including member compliance, overall prognosis (periodontic and endodontic) and the amount of available tooth structure should be documented for such procedures as crowns, bridges, and removable partial dentures. Evidence of history of poor oral hygiene, poor member self-care may result in denial.

Criteria for clinical or contractual Denial or Modification of Benefits Request:

II.R.4 Patient is no longer eligible or a member.

II.R.5 Procedure is not a covered benefit under the plan or the program.

II.R.6 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program

II.R.7 There is no documentation of evidence of need. Evidence of need may include, but is not limited to, radiographs, written narrative documentation, photos, and/or models supporting a diagnosis of decay, fracture, infection or other condition.

II.R.8 There is a more conservative treatment option within the professional standard of care (e.g. filling vs. crown, filling vs. prophylactic pulpotomy, etc.).

II.R.9 There exists an infection that must be treated prior to the requested procedure, or a procedure is requested when another procedure is required prior to the requested procedure for the optimal outcome, (i.e. treatment is not consistent with the optimal treatment sequence).

II.R.10 The tooth or implant does/would not have the adequate bone support and/or tooth structure for a favorable outcome.

II.R.11 The tooth, implant or proposed implant position is in an abnormal or unusual position, cannot be restored satisfactorily, or the restoration will not improve/restore function (e.g. lack of opposing tooth or pontic, lack of adequate arch integrity or inadequate occlusion).

II.R.12 The final restoration may be denied if a previously completed RCT is unsatisfactory, unstable, and/or symptomatic (e.g. incomplete, short fill, overfill, silver points, Sargenti paste, etc.).

II.R.13 Removable prosthesis or restoration/placement of implants may be denied due to physical limitations, systemic involvement, or emotional disturbances.

II.R.14 Adequate space is required for approval of replacement of tooth/teeth or restoration/placement of implants.

II.R.15 Procedure is not indicated in a primary tooth because the primary tooth will be replaced in the arch (e.g. laboratory fabricated crowns).

II.R.16 Replacement teeth may be denied when 1) there are adequate teeth in the arch to support the existing teeth for proper mastication (biting and chewing) and function and to prevent tooth movement or shifting (e.g. replacement of long-standing missing teeth in a stable occlusion), 2) Removable Partial Dentures or implants to replace 2nd and 3rd molars where there are no functional opposing teeth..

II.R.17 Benefits may be available only for the most inclusive procedure when covered by the plan.

II.R.18 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

II.R.19 When there is more than one restorative procedure that could adequately address the dental condition requiring treatment, the procedure may be recoded to the least-expensive acceptable service covered by the plan.

Criteria for Denial of Benefits Request due to insufficient submitted materials:

NOTE: Providers may resubmit Pre-Authorization with additional materials for review as a new request. Providers will receive written notification of the request for additional information to be submitted within 14 days. Upon receipt of the additional information, a decision will be rendered within 5 days.

II.R.20 PCD requirements for submission have not been met.

II.R.21 Additional information is needed in order to make a determination.

II.R.22 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of IV bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III. GUIDELINES FOR AUTHORIZATIONS FOR CLAIMS PAYMENT

The following Utilization Review guidelines apply for requests for Claims Payment for completed procedures, when covered by a particular WDS plan. Plans may vary in their scope of covered benefits. Retrospective review of treatment rendered may be appropriate when treatment did not undergo required prospective review, or when treatment rendered varied from the treatment previously reviewed and approved.

III.OS **Oral Surgery Claims**

Provider Requirements for Submission:

Third Molar Extractions

III.OS.1 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

III.OS.2 There must be acceptable radiographic, written, photographic, or other imaging justification for the need for the extraction(s).

III.OS.3 Extraction of third molars without evidence of need is not a covered benefit. Benefits are available for the removal of a third molar only when there is pathology associated with the tooth or when the third molar is in a position that jeopardizes the eruption or restoration of the adjacent second molar or causes potential damage to the second molar..

III.OS.4 The provider should document for each individual tooth the evidence of need for completing the extraction (e.g. symptoms, pericoronitis, pain, swelling, periodontal involvement, difficult to clean, impactions, poor prognosis).

Non-Third Molars Extractions and Other Covered Surgical Procedures

III.OS.5 There must be adequate quantity and quality of radiographs to support the diagnosis and classification of the procedure.

III.OS.6 Consultation fees are not covered when done on the same day as surgery. In the case of verifiable emergency referrals, exceptions may be made by the dentist reviewer.

III.OS.7 Requests for payment for removal of cysts, biopsies, etc., must be accompanied by a report.

Criteria for Approval of Payment:

III.OS.8 Evidence of need for the procedure. Benefits may be approved for those oral surgery procedures covered by the member's plan or program that are not within the scope of services typically provided by a PCD. This may include, but are not limited to, the following procedures when covered: those extractions that are classified as surgical, soft tissue impaction, partial bony impaction, or complete bony impaction; coronectomy of impacted teeth where neurovascular complications are likely; treatment of oral pathology (cysts, tumors, etc.); surgical placement of implants, surgical exposure (with or without attachment of bracket and chain to assist eruption) and procedures for the treatment of temporomandibular joint disturbances not typically provided by a general dentist.

III.OS.9 Signed and dated claim form evidencing that procedure was performed.

III.OS.10 If the PCD determined that the treatment is needed and the treatment is supported by the documentation submitted, then the specialist consultation is considered inclusive in the treatment. However, this is within the discretion of the dentist reviewer.

General Anesthesia and Sedation Consideration for Oral Surgery Claims:

III.OS.11 Consider the increased risks associated with general anesthesia and sedation.

III.OS.12 When employed during dental procedures, General Anesthesia and Sedation may be covered benefits for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone. It is assumed that the control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but not be limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedation may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site
e. Repeated failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternate method of pain/anxiety control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.
h. Behavior control for children (up to a prescribed age based on contractual allowance) who cannot be treated under local anesthetic, behavior modification techniques or a lesser level of sedation, and who require oral surgery procedures for the treatment of pathologic conditions.

III.OS.13 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:
a. To alleviate member apprehension, nervousness, fear, behavior management (except for pediatric members or physically compromised or other mentally challenged adult members as described above).
b. When diagnostic or non-invasive procedures are the only services provided.

Criteria for clinical or contractual Denial or Modification of Claims for Payment:

III.OS.14 Patient was not eligible at the time of service.
III.OS.15 Procedure was not a covered benefit under the plan or the program.
III.OS.16 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
III.OS.17 There was no submitted evidence of need.
III.OS.18 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service. This includes requests for payment for services that are within the scope of services typically provided by general dentists.
III.OS.19 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.
III.OS.20 Extraction of a tooth that has not been pre-authorized and/or was not planned for extraction.

Criteria for Denial of Claim Payment due to insufficient submitted materials

NOTE: Providers may resubmit Claims with additional materials for review as a new request.
III.OS.21 Requirements for submission had not been met (e.g. PCD did not properly refer).
III.OS.22 Additional information is needed in order to make a determination.
III.OS.23 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.E **Endodontic Claims**

Provider Requirements for Submission:

III.E1 The provider should submit dated diagnostic pre-op and post-op radiographs of the tooth for accurate and complete evaluation. The claim will be denied for incomplete submission if the radiographic documentation is incomplete.

III.E.2 If it is obvious that the treatment was needed, no written explanation is needed. Otherwise narrative may be helpful to ensure payment of completed services.

III.E.3.a Benefits are not available for endodontic treatment of a tooth with a poor or guarded prognosis. Poor or guarded prognosis includes, but is not limited to, a reasonable professional judgment that the treated tooth would likely require further endodontic or surgical intervention within three years or would otherwise be non-functional (e.g. no opposing tooth with no indication of reasonable plans for replacement of the opposing tooth).

III.E.3.b Benefits are not generally available for endodontic treatment of a tooth that has extensive caries, extensive existing restorations or extensive unsupported tooth structure that compromises the planned restoration such that crown lengthening is necessary which would result in unmaintainable furcation involvement, excessive mobility or a poor crown root ratio.

III.E.3.c If radiographic evidence suggests moderate to severe periodontal disease, the provider can submit documentation which includes the evaluation of the following: (pocket depth around the tooth, furcations, mobility and written documentation regarding active periodontal disease). Benefits are not available for the endodontic treatment of a tooth that appears to have an unfavorable periodontal prognosis, including but not limited to Class II or greater furcation involvement, Class II mobility, inadequate bone support.

Criteria for Approval of Payment:

III.E.4 Benefits may be approved for those endodontic procedures covered by the member's plan or program that are not within the scope of a PCD. This may include, but not be limited to the following: diagnostic procedures to establish the need for the performed treatment, consultations to assist the general dentist in establishing prognosis for teeth with incomplete cracks, consultations regarding teeth with calcification or other conditions that differ from the adjacent and contralateral teeth or are unusual for the age of the patient, endodontic retreatments, treatment of internal/external resorption, perforation or moderately to severely curved roots (dilacerated roots), apexifications/recalcifications, pulpal regeneration, apicoectomy/periradicular surgeries, retrograde fillings, root amputations, endosseous implants, , treatment of canal obstructions and/or hemisections. WDS considers pulp testing to be included in the covered examination. Any available diagnostics should be provided by the PCD to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Any available diagnostics should be provided by the PCD to WDS or to the endodontic specialist to avoid unnecessary repetition of services. Benefits for treatment of obstruction are considered inclusive in the global procedure for root canal therapy for instances of endodontic re-treatments, calcified canals and other calcifications such as pulp stones. In the case of re-treatments, the removal of existing posts, pins and build-ups is considered to be included in the benefit for the re-treatment procedure. However, at the discretion of the dentist reviewer, benefits may be available for other obstructions such as separated instruments, etc. The use of specialized materials (e.g. MTA, MTAD, etc.) is generally considered to be included in the procedure. No additional benefit is provided for specialized materials.

III.E.5 The root canal procedure appears to be properly accessed, prepared, condensed and filled as viewed in the post-operative radiograph.

Criteria for clinical or contractual Denial of Payment:

III.E.6 Patient was not eligible at the time of service. For root canal therapy that requires multiple stages, the patient must remain eligible continuously from the start to the finish of the root canal.

III.E.7 Procedure is not a covered benefit under the plan or the program.

III.E.8 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.E.9 There is no evidence of need or the treatment of the tooth will not improve/restore function.

III.E.10 The information submitted by the provider about the member's current dental condition does not meet the minimum requirement for approval of the service, including requests for payment for services that are within the scope of services typically provided by general dentists.

III.E.11 The destruction of the tooth is too severe (e.g. decay or defect extends below the bone level). Because of the periodontal compromises such treatment may cause, teeth that may need additional surgical treatment such as crown lengthening for placement of a final restoration may require additional documentation to support a favorable prognosis for approval.

III.E.12 Periodontal disease has destroyed the bone around the tooth.

III.E.13 Inadequate bone support.

III.E.14 The root canal outcome does not meet the standard of care (e.g. poorly accessed, prepared, condensed, perforated and/or filled.) Consideration should be given for reasonable explanations of unusual outcomes.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.

III.E.15 Requirements for submission had not been met (e.g. PCD did not properly refer).

III.E.16 Additional information is needed in order to make a determination.

III.E.17 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.PD <u>Pediatric Dentistry Claims</u>

Provider Requirements for Submission:

III.PD.1 Evidence of need for requested benefits, include, but are not limited to, a diagnosis of decay, fracture, infection or other dental condition with supporting radiographs and/or narrative. The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The provider must document if and why radiographs cannot be obtained. Diagnostic photographs may be accepted as a viable substitute for radiographs in cases when reasonable attempts to get radiographs have been unsuccessful and when photographs demonstrate the need for the requested procedures.

Criteria for Approval of Payment:

III.PD.2 Plans may only cover treatment by a pediatric dentist for members up to a pre-defined age, based on the provisions of the member's particular plan.

III.PD.3 There is no age restriction for GMC/LAPHP members.

III.PD.4 In cases where there were no radiographs submitted for preauthorization, consideration of payment is based on the pre-operative radiographs or appropriate photographs taken at the time of treatment. The radiographs submitted should be diagnostic and of acceptable quality.

III.PD.5 Evidence of need for the procedure is evident in the radiographs, photographs or by written documentation.

III.PD.6 In cases where multiple treatment procedures are requested, line-item approval/denial is acceptable. Narrative comments are recommended.

General Anesthesia, Conscious Sedation, Oral Conscious Sedation and Relative Analgesia Consideration for Pediatric Dentistry Claims:

III.PD.7 Consider the increased risks associated with sedation.

III.PD.8 When employed during dental procedures, General Anesthesia and Sedation may be a covered benefit for pain control and treatment of medically compromised members who are not candidates for care under local anesthesia alone, and/or behavior control for children (up to a prescribed age based on contractual allowance) who cannot be safely and comfortably treated under local anesthetic, behavior modification techniques or a lesser level of sedation. It is assumed that the

control of pain can be obtained through local anesthesia unless there is a professionally accepted reason why treatment under local anesthesia alone is contraindicated or is not expected to be sufficiently profound. In such cases where treatment under local anesthesia alone is not possible, and when covered by the member's WDS plan, benefits for general anesthesia or sedation may be available. Such reasons may include, but not be limited to:

a. Severely decreased mental capacity, severe and unmanageable behavior, Attention Deficit Disorder, Autism, etc. A letter from the member's physician may be required to verify the condition.
b. Spastic-type handicapping condition.
c. Prolonged (more than 30 minutes) or severe surgical procedures. Prolonged (more than 30 minutes) general anesthesia or sedations may be applicable when treatment cannot be reasonably broken down into smaller appointment blocks of time.
d. Acute infection at an injection site.
e. Failure of a local anesthetic in the control of pain and the member could not be successfully treated using a lighter sedation technique or alternative method of anxiety/pain control.
f. A verifiable contraindication to a local anesthetic agent. A provider's statement that such a condition exists or why a surgical procedure failed under local anesthesia may not be acceptable. Additional information from a dentist, physician or allergist, including, in some cases, progress notes from a failed attempt with local anesthetic, may be necessary to substantiate the contraindication and support the need for undergoing the additional risks associated with general anesthesia.
g. Medically compromising conditions.

III.PD.9 The use of General Anesthesia, Conscious Sedation, Oral Conscious Sedation or Relative Analgesia (Nitrous Oxide) is **not** a benefit:

a. When local anesthetic, behavior modification techniques or a lesser level of sedation is adequate to alleviate discomfort or apprehension, or when there is adequate member cooperation to complete necessary services.
b. When diagnostic, preventive or non-invasive procedures are the only services provided.

Criteria for clinical and contractual Denial or Modification of Claim Payment:

III.PD.10 Patient was not eligible at the time of service.
III.PD.11 Procedure is not a covered benefit under the plan or the program.
III.PD.12 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.
III.PD.13 The procedure is within the scope and/or responsibility of the PCD (i.e. prophy).
III.PD.14 Consultation fees are not covered when performed on the same day as treatment.
III.PD.15 No evidence of need.
III.PD.16 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definitions or WDS procedure code definition.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.
III.PD.17 Requirements for submission have not been met.
III.PD.18 Additional information is needed in order to make a determination.
III.PD.19 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information when needed by the reviewer to establish need or reasonable prognosis, etc..)

III.PR **Periodontic Claims**

Provider Requirements for Submission:

III.PR.1 The provider must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The radiographs must be current (taken within 4 months of the request). The provider must document if and why radiographs cannot be obtained.

III.PR.2 Full mouth periodontal charting includes, but is not limited to pocket depths, mobility, furcation involvement, recession, plaque score, bleeding score, and frenum pull sufficient to demonstrate the need for treatment. Most recent periodontal chart must be dated and within 4 months of the pre-authorization request.

III.PR.3 Evaluation including member compliance and prognosis should be present.

Criteria for Approval of Payment:

III.PR.4 Benefits may be approved for those periodontal procedures covered by the member's plan or program that are not within the scope of services typically performed by a general practitioner. This may include, but is not limited to the following: periodontal surgical procedures and surgical placement of implants. Approval for osseous surgery allows for full or partial quadrants for treatment of bony defects with periodontal pockets of 5 mm or greater with radiographic evidence of bone loss, and flap surgery for pockets 5 mm or greater with indication of active disease (e.g. bleeding on probing, infection or radiographic evidence of continuing bone loss) remaining after initial therapy of scaling and root planing, oral hygiene, and/or supplemental therapeutic protocols:
Partial – involvement of 1-3 contiguous teeth or bounded tooth spaces
Full – involvement of 4 or more contiguous teeth or bounded tooth spaces.

III.PR.5 Evidence of need should be supported by proper periodontal charting (dated within 4 months of the preauthorization request), radiographic evidence of bone loss and/or the presence of calculus, or written documentation by the provider. Evidence of need may include, but is not limited to, a diagnosis of periodontal disease as well as narrative and submitted documentation supporting a clinical judgment that surgical intervention will most likely provide for disease control and retention of teeth in question for at least 3 years with little chance for additional surgical intervention during that time period.

III.PR.6 Periodontal consultation may be approved if the PCD needed assistance with treatment planning and sequencing.

Criteria for clinical or contractual Denial or Modification of Claim Payment:

III.PR.7 Patient was not eligible at the time of service.

III.PR.8 Procedure is not a covered benefit under the plan or the program.

III.PR.9 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.PR.10 The procedure is within the scope and/or responsibility of the PCD. Such a procedure will be denied if the claim is submitted by the specialist (e.g. scaling and root planing).

III.PR.11 Poor prognosis (e.g. poor crown-to-root ratio, Class III mobility, Class II ore greater furcation involvement, evidence of poor oral hygiene compliance or maintenance), or other lack of evidence that the requested surgical procedure is likely to significantly improve the prognosis or need for treatment not established. Evidence of a history of poor oral hygiene, member non-compliance with instructions designed to maintain oral health, or dental neglect may result in denial for reason of poor prognosis.

III.PR.12 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: Providers may resubmit Claims with additional materials for review as a new request.

III.PR.13 Requirements for submission have not been met.

III.PR.14 Additional information is needed in order to make a determination.

III.PR.15 Dental Reviewer is not able to make a determination with the submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested, or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of bisphosphonate usage, tobacco use with associated poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

III.R **<u>Restorative Dentistry Claims</u> (including filling restorations, crowns, bridges, implant-supported restorations and removable prosthetics)**

Provider Requirements for Submission:

III.R.1 The PCD must submit mounted (with the left and right sides labeled or distinguished) and dated full-mouth radiographs or digital radiographs. The provider must document if and why radiographs cannot be obtained. When full mouth radiographs are not available, a sufficient number of radiographs (tooth in question, opposing arch, and contra-lateral views) and appropriate views (periapical, bitewing and/or panoramic radiographs) to justify the proposed treatment must be submitted.

III.R.2 Diagnostic copies or original radiographs are acceptable.

III.R.3 Evaluation by the PCD: including member compliance, overall prognosis (perio and endo) and the amount of available tooth structure should be documented for such procedures as crown, bridges, and removable partial dentures. Evidence of history of poor oral hygiene, poor member self-care may result in denial.

Criteria for clinical or contractual Denial or Modification of Payment:

III.R.4 Patient was not eligible at the time of service. For crowns, veneers, bridges, and prosthetics, the patient must be eligible continuously from the starting date to the finishing date.

III.R.5 Procedure is not a covered benefit under the plan or the program.

III.R.6 Procedure is to facilitate service(s) which are not covered benefits under the plan or the program.

III.R.7 There is no documentation of evidence of need. Evidence of need may include, but is not limited to, radiographs, written narrative documentation, photos, and/or models supporting a diagnosis of decay, fracture, infection or other condition.

III.R.8 There was a more conservative treatment option within the professional standard of care (e.g. filling vs. crown, filling vs. prophylactic pulpotomy, etc.).

III.R.9 There exists an infection that must be treated, or a procedure is requested when another procedure is required prior to the requested procedure for the optimal outcome, (i.e. treatment is not consistent with the optimal treatment sequence).

III.R.10 The tooth or implant did/would not have the adequate bone support and/or tooth structure for a favorable outcome.

III.R.11 The restoration did not improve/restore function. There is a lack of an opposing tooth, adequate arch integrity or adequate occlusion.

III.R.12 The final restoration may be denied if a previously completed RCT is unsatisfactory, unstable, and/or symptomatic (e.g. incomplete, short fill, overfill, silver points, Sargenti paste, etc.).

III.R.13 Removable prosthesis or restoration/placement of implants may be denied due to physical limitations, systemic involvement, or emotional disturbances.

III.R.14 Adequate space is required for approval of replacement of tooth/teeth or restoration/placement of implants.

III.R.15 Procedure is not indicated in a primary tooth because the primary tooth will be replaced in the arch (e.g. laboratory fabricated crowns).

III.R.16 Replacement teeth may be denied when there are 1) adequate teeth in the arch to support existing teeth for proper mastication (biting and chewing) and function and to prevent tooth movement or shifting (e.g. replacement of long-standing missing teeth in a stable occlusion), or 2) Removable Partial Dentures or implants to replace 2nd and 3rd molars where there are no functional opposing teeth.

III.R.17 Benefits may be available only for the most inclusive procedure when covered by the plan.

III.R.18 The procedure may be recoded when the submitted materials do not demonstrate that the procedure code used is consistent with the American Dental Association ("CDT") procedure code definition or WDS procedure code definition.

III.R.19 When there is more than one restorative procedure that could adequately address the dental condition requiring treatment, the procedure may be recoded to the least-expensive acceptable service covered by the plan.

Criteria for Denial of Claim Payment due to insufficient submitted materials:

NOTE: PCDs may resubmit Claims with additional materials for review as a new request.

III.R.20 PCD requirements for submission have not been met.

III.R.21 Additional information is needed in order to make a determination.

III.R.22 Dental Reviewer is not able to make a determination with the PCD submission (e.g. non-diagnostic radiographs, poor copies of records, illegible written documentation, inconsistent information, incorrect tooth number or service requested, or incomplete information such as failure to document tooth number and/or service requested or supporting clinical or diagnostic information needed by the reviewer to establish need, or lack of documentation of significant contributory medical history (e.g. uncontrolled diabetes, past history of I.V. bisphosphonate usage, tobacco use associated with poor oral hygiene or other contributing factors, xerostomia, radiation exposure, etc.)

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION IV – UTILIZATION MANAGEMENT	
IV.D-UM Decision Timeframes	
UMC Chair:	Approved on:
QIC Chair:	Approved on:

IV.D1 – UM DECISION TIMEFRAMES POLICY

It is the policy of Western Dental Services, Inc. ("WDS") to render utilization decisions and send notification of the decision within the timeframes set out under law. Providers may request an authorization for dental health care services by mail, by facsimile and telephonically.

In cases where the review is retrospective, the decision shall be communicated to the enrollee who received services, or to the enrollee's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination. In addition, it shall be communicated to the provider in a manner that is consistent with current law.

For an enrollee who faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, it is WDS policy to provide the decision in a timely fashion, not to exceed 72 hours after receipt of the information reasonably necessary and requested by WDS to make the determination. This also includes situations for which the timeframe for the decision-making process for a routine referral would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.

IV.D2 – UM DECISION TIMEFRAMES PROCEDURES

I. Routine Referrals

- For routine referrals, the decision to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of dental health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days, from the receipt of the information reasonably necessary and requested by WDS to make the determination.

- Decisions to modify, delay or deny requests by providers for authorization prior to, or concurrent with, the provision of dental health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision by email, facsimile or telephone, and all decisions will be communicated in writing within two business days.

- Decisions to approve, modify, delay or deny all or part of the requested dental health care services prior to the provision of services shall be communicated to the enrollee and/or the enrollee's authorized representative in writing within two business days of the decision.

- Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of dental health care services to enrollees shall specify the specific dental health care services approved.

II. Urgent Referrals

- For urgent referrals, the decision to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of dental health care services to enrollees, shall not exceed 72 hours

following receipt of the information reasonably necessary and requested by WDS to make the determination.

- Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of dental health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision.

- Decisions resulting in denial, delay, or modification of all or part of the requested dental health care services shall be communicated to the enrollee and/or the enrollee's authorized representative in writing within two business days of the decision.

- Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of dental health care services to enrollees shall specify the specific dental health care services approved.

III. Retrospective Review

- For retrospective review, the decision to approve or deny the previous provision of dental health care services to enrollees, shall be communicated within 30 days after receipt of the information reasonably necessary and requested by WDS to make the determination.

IV. Incomplete Submissions or Requests

There may be situations where WDS is not in receipt of the information reasonably necessary to make a decision to approve, modify, or deny the request for authorization because of the following:

A. WDS is not in receipt of all of the information reasonably necessary and requested, or;
B. WDS requires consultation by an expert reviewer, or;
C. WDS asked that an additional examination or test be performed upon the enrollee, (provided the examination or test is reasonable and consistent with good medical practice).

In such situations,

- WDS shall immediately upon the expiration of the timeframe specified for routine and urgent requests, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever comes first, notify the provider and enrollee (and/or the enrollee's authorized representative), in writing. The written notification shall state that WDS cannot make a utilization review decision within the required timeframe, and specify the information requested but not received, or the expert reviewers to be consulted, or the additional examinations or tests required.
- WDS shall also notify the provider and enrollee (and/or the enrollee's authorized representative) of the anticipated date on which a decision may be rendered.
- Upon receipt of all information reasonably necessary and requested by WDS, WDS shall approve, modify, or deny the request for authorization within the time frames specified for routine and urgent requests.

IV.D3 - SCOPE

This policy applies to all WDS enrollees, WDS Staff Model Offices and individual Primary Care Dentists (PCD) and Specialists.

Western Dental® SERVICES, INC.

530 South Main Street
Orange, CA 92868
1-800 992-3366

WDS REFERRAL FORM

PLEASE USE ORIGINAL FORM-COPIES WILL NOT BE ACCEPTED

REFERRAL FOR:
☐ **OS** ☐ **Pedo** ☐ **Endo** ☐ **Perio** ☐ **Ortho**
☐ **X-rays included, how many?** _____

☐ Group # _____
Plan # _____
☐ Other _____
(Medi-Cal, etc...)

CLAIM #

THIS REFERRAL IS VALID FOR 45 DAYS UNLESS ENROLLEE BECOMES INELIGIBLE. ELIGIBILITY MUST BE CONFIRMED PRIOR TO SERVICES BEING RENDERED.

PROVIDER NAME	PROVIDER #		PHONE #
STREET ADDRESS	CITY	STATE	ZIP
PATIENT NAME	SOCIAL SECURITY # / CIN#		BIRTH DATE
MEMBER NAME	SOCIAL SECURITY #		
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE #	EMPLOYER		GROUP/ MEMBER#

TO BE COMPLETED BY REFERRING DENTIST AND SPECIALIST			TO BE COMPLETED BY SPECIALIST						
TOOTH # OR LET.	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO.	DAY	YEAR	PROCEDURE NUMBER		FEE	

PLEASE ATTACH ANY SUPPORTING NARRATIVE / DOCUMENTATION NECESSARY

1. General dentist cannot perform treatment because (please be specific): _____

_____

_____

2. Symptoms, pathology or other condition necessitating treatment:
   - For extraction of third molars, please indicate the pathology necessitating the extractions on a tooth-by-tooth basis. Please note that the prophylactic removal of non-pathologic third molars may NOT be a covered benefit.

_____

_____

   - For periodontal referral benefits, please include full-mouth x-rays, initial pocket charting, the dates of SRPs and any periodic maintenance, and the post-SRP pocket charting.
   - For pediatric referral benefits, please indicate the qualifying medical condition or dates of unsuccessful attempts to treat the child.
   - For endodontic referral benefits, please include diagnostic periapical x-ray(s), including bite-wing x-ray(s) for posterior teeth.

IN MY PROFESSIONAL JUDGEMENT, THE TREATMENT LISTED REQUIRES A SPECIALIST.

REFERRING DENTIST SIGNATURE _____ DATE _____

MEMBER - PLEASE CONTACT THIS SPECIALTY PROVIDER FOR INDICATED SERVICES

RENDERING PROVIDER NAME_____ I.D. # _____

ADDRESS _____

CITY, STATE, ZIP _____ PHONE # _____

PROVIDER SIGNATURE_____MEDICAL BILLING # _____

RENDERING PROVIDER:

- SPECIALTY CONSULTATION MAY NOT BE PAYABLE ON SAME DAY AS TREATMENT.
- PLEASE RETURN X-RAYS ON COMPLETION OF TREATMENT TO DENTIST ABOVE.
- IF YOU ARE A CONTRACTED PROVIDER, YOU MUST BILL FOR SERVICES WITHIN 90 DAYS.
- IF YOU ARE A NON-CONTRACTED PROVIDER, YOU MUST BILL FOR SERVICES WITHIN 180 DAYS.

FOR WDS USE ONLY

VERIFICATION

ELIGIBLE ☐ YES ☐ NO

VERIFIER: _____ DATE: _____

REFERRAL STATUS:

☐ DEBIT ☐ NO DEBIT ☐ PARTIAL DEBIT $ _____

DEPT. HEAD APPROVAL _____

BENEFIT STATUS

☐ REFERRAL APPROVED ☐ DENIED ☐ PENDING

REMARKS: _____

_____

REVIEWED BY: _____

DATE: _____/_____/_____ TIME: _____ AM PM

***PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS**

INSTRUCTIONS FOR REFERRAL

For Primary Care Dentist

1. Complete the "Referral Form 046-A" marking the appropriate specialty box on the top part of the referral form. In the lower portion of the form complete the reason for the referral, the description of specialty services requested and all applicable CDT procedure code(s). Be sure to include diagnostic x-rays, pocket depth charting (if applicable), and your clinical evaluation (listing all member symptoms). DO NOT fill in the specialist's name and address; this will be done by the administrative office, unless you determine that the patient should see a specific specialist.

2. Send the WHITE, PINK, BLUE, & GREEN COPIES to Western Dental Services at the address below. The Plan will forward the approved referrals to the member, specialist and general dentist.

For Specialist

Upon completion of the approved treatment, please submit for payment on an ADA claim form direct to Western Dental. If you are billing on a WDS Specialty Referral form please include your signature in the designated area. Your total reimbursement will be a combination of the member's co-payment, if any, and payment from Western Dental to equal your contracted amount.

Mail the completed form to:

Western Dental Services, Inc.
ATTN: Claims Department
P.O. Box 14227
Orange, CA 92863

If you have any questions regarding a member's benefits or eligibility, please call our Member Services Department at 1-800-992-3366.

IN ORDER TO CONFIRM THE PLAN'S RECEIPT OF YOUR CLAIM (REQUEST FOR PAYMENT), YOU MAY CALL MEMBER SERVICES AT 1-800-992-3366

THE PLAN MAY CONTEST OR DENY A CLAIM, OR PORTION THEREOF, BY NOTIFYING THE PROVIDER, IN WRITING, WITHIN 30 WORKING DAYS OF RECEIPT OF CLAIM. THE PROVIDER HAS THE RIGHT TO CONTEST, THROUGH THE PROVIDER DISPUTE MECHANISM, THE PLAN'S DECISION ON A CLAIM, OR PORTION THEREOF, BY NOTIFYING THE PLAN, IN WRITING, WITHIN 30 WORKING DAYS OF
THE DECISION. THE OFFICER RESPONSIBLE FOR RECEIVING AND RESOLVING PROVIDER DISPUTES IS THE VICE PRESIDENT OF THE BENEFITS DIVISION.

INSTRUCTIONS FOR ORTHODONTIA REFERRALS

ORTHODONTIA REFERRAL

If the member requires orthodontia, please contact WDS at **1-800-992-3366** for the name, phone number and address of a local Orthodontic WDS provider or refer to the online provider directory at http://www.westerndentalbenefits.com.

IX.

PROCESSING CLAIMS

PROCESSING CLAIMS

The following section contains important information about claim policies and procedures.

WESTERN DENTAL SERVICES
POLICIES & PROCEDURES

POLICY: Timely Claims Payment

Western Dental Services, Inc. (the "Plan") provides reimbursement to providers for dental treatment in a timely manner, not to exceed 30 working days from the date of receipt of the request for payment provided the claim is submitted within 90 days of the date of service for contracted providers and 180 days of the date of service for non-contracted providers. Western Dental will provide a clear, accurate and written description for the reason for the non-payment of a claim (pended or denied) and provides a mechanism for providers to appeal claims decisions through its Provider Dispute Resolution Process.

PROCEDURES:

Submission of Claims

Contracting providers must submit claims within 90 days from the date of service. Non-contracting providers must submit claims within 180 days from the date of service.

Restorative, pedodontic, oral surgery and endodontic claims must include applicable pre and post-operative x-rays as outlined in your Provider Guide. Periodontal claims must include applicable pre and post-operative x-rays and periodontal charting as outlined in your Provider Guide.

Claims should be submitted by mail to:

Western Dental Services
Plan Claims Department
P.O. Box 14227
Orange, CA 92863

Claims may be delivered by courier or fax to:

Western Dental Services
Plan Claims Department
530 S. Main St.
Orange, CA 92868

Fax: **1-714-571-3647**

To confirm receipt of a claim or for claim inquires please call the Claims Department at **1-800-992-3366.**

Disclosure of Fee Schedule and Other Information Electronically

Initially upon contracting all provider offices are given a Provider Guide that includes all applicable fee schedules and plan information. Fee schedules and payment policies and rules can be provided electronically upon written request by the provider.

Acknowledgment of Claims

The Plan will identify and acknowledge the receipt of each claim, and will disclose the recorded date of receipt to the provider within 15 working days from the date the Plan receives the claim.

Time for Reimbursement

The Plan will process all complete claims within 30 working days of the date of receipt. A complete claim is defined as a claim that contains all of the reasonably relevant information and documentation (claim form, radiographs, and clinical notations) necessary to determine the Plan's liability for the claim.

Amount of Reimbursement

For contracted providers, the Plan will pay claims in accordance with the terms of the provider's written contract with the Plan. For non-contracted providers, the Plan will pay the reasonable and customary value of the services rendered, based on statistically credible information that is updated at least annually and takes into consideration the provider's training, qualifications and length of time in practice, the nature of the services provided, the fees usually charged by the provider, the prevailing provider rates charged in the general geographic area in which the services were rendered, other relevant aspects of the economics of the provider's practice, and any unusual circumstances in the case.

Denying, Adjusting or Contesting Claims

For each claim that is denied, adjusted or contested, the Plan will provide a clear written explanation of the specific reasons for the Plan's action within the Time for Reimbursement stated above.

The Plan will deny a claim, or a portion of a claim, for an ineligible person, for excluded procedures, for procedures where there is no coverage, or when it is submitted after the allowable time period.

Incomplete Claims

The Plan may contest a claim that does not contain all of the reasonably relevant information necessary to accurately review the claim. The Plan will provide the provider with a clear and accurate written explanation of why additional information is needed. The provider shall
provide the information within 10 working days from the date of the request. The Plan will have 15 days to request any additional information necessary to make the claim complete. The Plan will have 30 working days from the date of receipt of the additional information from the provider to reconsider the claim.

Overpayment of Claims

If the Plan determines it has overpaid a claim, the Plan will send the provider a written request for reimbursement within 365 days from the date of payment. The Plan will identify the claim, patient name, date of service, and will provide a clear explanation of the basis upon which the Plan believes the amount paid was in excess of the amount due.

A Provider may contest the Plan's notice of overpayment of claim, in writing, within 30 working days, through the Provider Dispute Resolution Process.

If the provider does not contest the notice of overpayment, the provider shall reimburse the Plan within 30 working days from the receipt of the notice of overpayment. The Plan may offset the amount stated in the uncontested notice of overpayment against the provider's current claims submission if provider has entered into a contract that allows for such offset. The Plan will provide a detailed written explanation identifying the specific overpayment(s) pertaining to the offset against the current claims.

Payment of Late Claims

If a complete claim has not been contested or denied within 30 working days from the date of receipt of the claim, the Plan will pay interest at the rate of 15% per annum for the period of time that the payment is late. Late payments on a complete claim for emergency services and care which is neither contested nor denied will include the greater of $15 for each 12 month period or portion thereof on a non-prorated basis or interest at the rate of 15 percent annum for the period of time that the payment is late.

Interest shall automatically be included with the claims payment. In the event that interest is not automatically included, the Plan pays a $10.00 penalty for that late claim. If the interest due on an individual late claim payment is less than $2.00 at the time that the claim is paid, the Plan may pay the interest on that claim along with interest on other such claims within 10 calendar days of the close of the calendar month in which the claim was paid. The Plan will include a statement identifying the specific claims for which the interest is paid and will set forth a method for calculating interest on each claim and will document the specific interest payment made for each claim.

Amendments to this Policy

The Plan shall provide 45 days prior written notice before instituting any changes, amendments, or modifications to this policy.

Receipt of Claims by Providers

If a provider erroneously received a claim that should be paid by the Plan, the provider must forward the claim to the Plan within 10 working days of the receipt of the claim.

Provider Disputes

Provider may file disputes regarding this Timely Claims Payment Policy and Procedure through the Provider Dispute Resolution Process, as described in this Manual.

X.

GRIEVANCE

GRIEVANCE

The following section contains important information about the grievance process and how you will assist WDS plan members with filing a grievance.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION II – GRIEVANCE AND APPEALS	
II.A - Grievance System Description and Filing Requirements	
QIC Chair:	Approved on:
Board of Directors Chair/CEO:	Approved on:

II.A1 - POLICY:

It is the policy of Western Dental Services, Inc., ("WDS") to maintain, provide and support a grievance system and mechanism for enrollees to file grievances. The Plan will ensure the grievance system is approved by the Department of Managed Health Care ("DMHC") and the Department of Health Care Services ("DHCS"), if applicable and in accordance to regulations and contractual requirements.

For the purposes of the policies relating to grievances, the following definitions shall apply:

> A "grievance" is defined as a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or an enrollee's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
>
> "Complaint" is the same as "grievance."
>
> "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.
>
> "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system.
>
> "Pending" means that the grievance has not reached a final conclusion with respect to the enrollee's submitted grievance for any reason, including referral to external dispute resolution systems.

Grievances shall be reviewed and resolved within 30 calendar days of receipt by the Plan. If the complainant does not accept the resolution, the enrollee may appeal the decision as noted below:

- The grievance and any associated appeal must be resolved within 30 days from the date the grievance was received by the Plan. In the event an appeal is received after the thirty-day period, the complainant will be advised in writing that he/she may appeal the grievance to the DMHC. Should the complainant submit new or additional information regarding the grievance, or should the complainant raise a new concern in a letter of appeal that has passed the thirty-day period, a new grievance shall be opened for that complainant.

II.A2 - STRUCTURE:

I. GRIEVANCE COMMITTEE and QUALITY IMPROVEMENT COMMITTEE

The Grievance Committee ("GC") meets on a weekly basis, or more frequently as needed. The Patient Relations Supervisor chairs the committee and is responsible for the oversight of the committee's activities. The GC reports on a quarterly basis to the Quality Improvement Committee ("QIC"). At least annually, the QIC evaluates the

Grievance Policies and Procedures for revision and updates, oversight and the utilization of emergent patterns of grievances to formulate policy changes and procedural improvement. Formal adoption of the Policies and Procedures by the Plan shall be evidenced by the dated signature of the QIC Chair and the Board of Directors Chair and/or as evidenced by meeting minutes.

Membership of the GC consists of the following:

- Patient Relations Supervisor, Chair
- Chief Dental Officer, Dental Director or Dentist Designee
- Dental Consultant
- Plan Member

Responsibilities of the GC include, but are not limited to, the following:

- Adequate consideration of enrollee and provider grievances, and rectification, when appropriate;
- Reporting responsibilities to the QIC; and
- Forwarding potential quality of care issues to the Peer Review Committee for review, as necessary

II. GRIEVANCE SYSTEM – PERSONS RESPONSIBLE

CHIEF DENTAL OFFICER

The Chief Dental Officer, who holds an active dental license, is the designated person responsible for the grievance system. The Chief Dental Officer shall have primary responsibility for maintenance of the grievance system, review of grievance operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the Plan's administration. The Chief Dental Officer shall ensure that there is adequate consideration of enrollee and provider grievances and rectification, when appropriate.

VICE PRESIDENT OF QUALITY MANAGEMENT

The Vice President of Quality Management reports to the Chief Dental Officer and shall ensure implementation of the Grievance system's operational processes. This includes, but is not limited to:

- Oversight of regulatory timeframes and requirements
- Identification of grievance trends by provider
- Oversight of case management
- Follow-up of corrective action measures
- Reporting of the Grievance System activities to the QIC
- Establishing and maintaining at least one telephone number for the filing of grievances, located within each service area, including facilities of providers that are used by the Plan;
- Ensuring access to and assistance in the filing of grievances at each location where grievances may be submitted;
- Ensuring that grievance forms and a description of the grievance procedure are available at each Plan facility and are provided to enrollees promptly upon request;
- Ensuring that grievance forms and a description of the grievance procedure are available on the Plan's website;
- Ensuring grievance and appeals information is provided and updated as necessary to the enrollee and providers through the Member Handbook, Evidence of Coverage ("EOC"), Provider Guide, brochures, letters and other applicable forms of written communication;
- Ensuring that the grievance system meets the linguistic and cultural needs of the Plan's enrollee population
- Reviewing grievances regarding the services and operations of the Plan.
- Reporting responsibility to the Chief Dental Officer;
- Ensuring Expedited Review of Urgent Grievance Requirements; and
- Submitting a quarterly report to the DMHC describing grievances that were or are pending and unresolved for 30 days or more

PATIENT RELATIONS SUPERVISOR

The Patient Relations Supervisor shall chair the GC and coordinate the activities of the IRU/Patient Relations Department. This includes, but is not limited to:

- Coordinating correspondence with all parties involved;
- Gathering information and documents to be provided to the GC;
- Entering of data and grievance cases;
- Maintaining the Grievance Log;
- Coordinating the GC members attendance at meetings;
- Generating documents and reports for tracking, trending and analysis of grievances. This includes reports of grievances aggregated and tabulated by type or category; and
- Coordinating Grievance System's activities with quality management activities (i.e. Peer Review and Utilization Management)

II.A3 - SCOPE:

The scope of the grievance system shall include all enrollees and providers in the Western Dental Services, Inc. Plans.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION II – GRIEVANCE AND APPEALS	
II.B - Grievance System Process Requirements	
QIC Chair:	Approved on:
Board of Directors Chair/CEO:	Approved on:

II.B1 – GRIEVANCE SYSTEM PROCESS REQUIREMENTS POLICY

It is WDS' policy to ensure that there is a mechanism in place to process and resolve grievances.

II.B2 – MEMBER GRIEVANCE PROCESS

The Grievance System is designed to provide an objective process to resolve member grievances in a timely manner. It also is designed to provide a mode of grievance prevention and quality improvement by tracking, monitoring and reporting grievance trends. The grievance process identifies areas for improvement and follow-up.

PROCEDURES:

- A member may file a grievance either in writing or orally at any Plan facility or by contacting the Plan directly. Grievances may also be submitted via the Plan's website. The Plan will allow members to file grievances for at least 180 calendar days following any incident or action that is the subject of the member's dissatisfaction.

- A written record shall be made for each grievance received by the Plan, including 1) the date received, 2) identification of the individual recording the grievance, 3) a summary of the grievance issue(s) and 4) disposition of the grievance. The written record of grievances shall be reviewed periodically by the Board of Directors of WDS, the Public Policy Committee and by the Chief Dental Officer.

- All provider offices contracted to provide services to members must post the Plan's toll-free telephone number for assistance in filing a grievance.

- Assistance in the filing of grievances shall be available at each provider's office.

- A copy of the grievance procedures and Incident Form shall be provided to the enrollee upon request.

- The Plan's grievance system shall address the linguistic and cultural needs of its member population as well as the needs of members with disabilities. The Plan shall provide assistance for those with limited English proficiency ("LEP") or with a visual or other communicative impairment. This assistance shall include, but not be limited to, translations of grievance procedures, forms, and Plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid in communication. The Plan provides grievance forms in its threshold language(s) as defined in the Plan's Language Assistance Program.

- If the grievance includes concerns about the Patient Relations Supervisor, Plan Representative or designee, the Incident Form is routed to the Vice President of Quality Management and or a designee for resolution.

- For cases that cannot be resolved within 30 days of the Plan's receipt of the grievance, the Plan shall send written notification to the complainant of the pending status of the complaint. The Patient Relations Supervisor shall maintain a system of aging of grievances that are pending and unresolved for 30 days or more. In the event that a grievance is not resolved in 30 days, the Vice President of Quality Management shall be notified.

- The Plan's grievance system shall track and monitor grievances received by the Plan. The system shall: (1) Monitor the number of grievances received and resolved, whether the grievance was resolved in favor of the complainant or the Plan, and the number of grievances pending over 30 days. The system shall track grievances under the categories of Commercial and Medi-Cal contracts. The system shall also indicate whether an enrollee grievance is pending at: the Plan's internal grievance system, the DMHC consumer complaint process, the DMHC Independent Medical Review system, an action filed or before a trial or appellate court, arbitration, the Medi-Cal fair hearing process or other dispute resolution process. (2) The system shall indicate the total number of grievances received, pending and resolved in favor of the complainant at all levels of grievance review and to categorize the issue or issues as coverage disputes, disputes involving medical necessity, quality-of-care, access to care, waiting time at appointments, quality of service and other issues.

- Quarterly, the Patient Relations Supervisor shall generate reports of grievances aggregated and tabulated by type and category for review by the Chief Dental Officer and the Quality Improvement Committee.

- The Vice President of Quality Management shall submit a quarterly report to the DMHC describing grievances that were or are pending and unresolved for thirty (30) days or more. The report shall include the number of grievances referred to external review processes known to the Plan, including, but not limited to, the Medi-Cal fair hearing process, the DMHC consumer complaint process or the DMHC Independent Medical Review system as of the last day of each quarter.

- The Grievance Files shall contain copies of grievances and responses that the Plan is required to maintain and shall be kept for five (5) years. Grievance Files shall include a copy of all dental records, documents, evidence of coverage and/or other relevant information upon which the Plan relied to reach its decision.

- It is the Plan's policy to ensure that there is no discrimination against a member (including cancellation of the contract) on the grounds that the complainant filed a grievance.

II.B3 – PATIENT GRIEVANCE PROCESS

The Grievance System is also designed to ensure that patients at WDS staff model offices who are members of other Knox-Keene licensed dental plans have access to their plan's grievance system for resolution of concerns in a timely manner. As such, it is the policy of WDS to refer all correspondences that 1) are received from patients who are members of other Knox-Keene licensed dental plans, 2) meet the definition of a "grievance" in WDS Policy II.A Grievance System Description and Filing Requirements, and 3) do not meet the criteria for "exempt grievances" as described in the DMHC's Technical Assistance Guide that is in effect at the time to the responsible Knox-Keene plan. The procedure is as follows:

- Within three business days of receipt, Patient Relations will forward the grievance to the responsible Knox-Keene plan(s).

Western Dental SERVICES, INC.

MEMBER INCIDENT FORM

P.O. Box 14227
Orange, CA 92863
1-800-992-3366 / 1-714-571-3675

PLEASE CONSULT THE DENTAL OFFICE FOR ASSISTANCE IN COMPLETING THIS FORM. Please return this form to the address listed above. You will receive a written response.

Date of Incident

Office Address and Dentist(s) Name

Member's Name (please print)

Patient's Name (please print) **Date of Birth**

Home Address, City, State, & Zip Code

Name of Insurance **Dental Plan #**

Daytime Phone # **Evening Phone #**

Group # **Member #** **Chart #**

DESCRIPTION OF INCIDENT (if applicable, tooth location, i.e., upper left, upper right, lower left, lower right):

HOW WOULD YOU LIKE THIS MATTER RESOLVED?

Have you discussed your concerns with the dental office and/or the dentist? ☐ **Yes** ☐ **No**

Signature Mr./Mrs./Ms. (circle one) **Date**

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-992-3366** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

Western Dental SERVICES, INC.

FORMULARIO DE INCIDENTE PARA PACIENTES

P.O. Box 14227
Orange, California 92863
1-800-992-3366 / 1-714-571-3675

INSTRUCCIONES: Por favor de una descripción completa del incidente. Incluya la fecha, el dentista o personal involucrado, lo que paso, y como se puede resolver el incidente a su satisfacción.

Fecha del Incidente | **Ubicación de la Oficina y/o Nombre del Dentista(s)**

Nombre del Miembro (por favor imprima) | **Nombre del Paciente (si es diferente, por favor imprima)**

Dirección | **No. de Grupo** **No. de Miembro** **No. de Expediente**

Ciudad, Estado, Código Postal | **No. de Teléfono (día)** **No. de Teléfono (noche)**

Descripción del incidente, (si aplica, incluya ubicación del diente(s), por ejemplo, arriba/izquierda, arriba/derecha, abajo/izquierda, y/o abajo/derecha, o especifique el número de diente(s) si lo sabe):

¿Cómo le gustaria resolver este incidente?

Converso con el gerente de la oficina sobre sus preocupaciones? ☐ **Si** ☐ **No**

Firma **Sr.** **Sra.** **Srita.** (indique uno) **Fecha**

"El Departamento de Atención Administrada de la Salud es responsable por regular planes de cuidado y servicio médico. Si usted tiene una queja en contra de su plan, usted debe presentar primero un reclamo ante su plan médico al **1-800-992-3366** antes de presentar un reclamo ante el Departamento de Atención Administrada de la Salud. Utilizar este procedimiento de quejas no prohíbe ningún derecho legal o remedios potenciales que pueden estar disponibles para us-ted. Si usted necesita ayuda con una queja que implica una emergencia, una queja que no ha sido resuelta satisfactoriamente por su plan de salud, o una queja que no ha sido resuelta en más de 30 días, usted puede llamar al departamento para obtener asistencia. Usted puede también ser elegible para una Revisión Médica Independiente (IMR). Si usted es elegible para una IMR, el proceso de IMR proporcionará una revisión imparcial de las decisiones médicas tomadas por el plan de salud relacionado con la necesidad médica de un servicio propuesto o el tratamiento, decisiones de cobertura para los tratamientos que son experimentales o de naturaleza investigativa y disputas por el pago de servicios de emergencia o servicios médicos urgentes. El departamento también tiene un número de teléfono gratis **(1-888-466-2219)** y una linea de TDD **(1-877-688-9891)** para personas con impedimentos de habla y oido. El sitio web de internet del departamento **www.dmhc.ca.gov** tiene formularios de queja, aplicaciones para una IMR e instrucciones en linea."

PROVIDER DISPUTE RESOLUTION PROCESS

OBJECTIVE

Western Dental Services Inc. (the "Plan") has developed a standard dispute resolution process in order to provide a fast, fair and cost-effective dispute resolution mechanism to process and resolve disputes between the Plan and providers. The Plan will not discriminate or retaliate against a provider (including, but not limited to, the cancellation of the provider's contract) because the provider filed a provider dispute.

PROCEDURE

Notice

Whenever the Plan contests, adjusts or denies a claim, the provider shall receive notice of the availability of the provider dispute resolution process, the procedures for obtaining forms and instructions, and the mailing address for filing a provider dispute.

Submission of Disputes

A. Providers can submit oral or written disputes to the Plan to do one or more of the following:

1) Challenge, appeal or request reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested by the Plan;

2) Seek resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered); or

3) Dispute a request for reimbursement of an overpayment of a claim

There is no cost to the provider to participate in this dispute resolution process. However, the Plan will not reimburse the provider for costs incurred in connection with utilizing the dispute resolution process.

Grievances submitted on behalf of members are resolved though the member grievance process, not the provider dispute resolution process.

B. Disputes must include at a minimum:

1) The provider's name, identification number (for contracting dentists), and contact information; and

2) If the dispute concerns a claim or request for reimbursement of an overpayment of a claim, clear identification of the disputed item (including the claim number), the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; and

3) If the dispute is not about a claim, a clear explanation of the issue and the provider's position thereon; and

4) If the dispute involves a member or group of members, the name and identification number(s) of the member or members, a clear explanation of the disputed item, including the date of service and the provider's position thereon.

C. Disputes can be mailed to the Plan at the following address:

Western Dental Services, Inc.
Attention: Provider Relations
530 South Main Street, Suite 110
Orange, California 92868
(800) 992-3366

Providers may wish to use the attached Provider Dispute Form to submit a dispute to the Plan.

Submission of Multiple Disputes

Providers may submit similar multiple claims disputes and other billing or contractual disputes as a single provider dispute. The Plan will assign a case number to each claim that is being disputed. Each disputed claim will be treated as an individual dispute and will be assigned its own case number.

Time Frame for Submissions

Providers have 365 days from the date of the Plan's action to submit a provider dispute. If a provider disputes the Plan's failure to take action on a claim, the provider has 365 days from the last date on which the Plan could have either paid, denied, or contested the claim (consistent with claims payment timeliness rules) to submit the dispute.

Incomplete Submissions

The Plan will return a provider dispute that is missing information required by this provider dispute resolution process, if such information is not readily accessible to the Plan. The Plan will notify the provider in writing of the incomplete submission and will clearly identify the information necessary to resolve the dispute. The Plan will not ask a provider to resubmit information that was previously submitted to the Plan as part of the claims process, unless the Plan has previously returned that information to the provider.

Acknowledgement of Disputes

Provider disputes will be acknowledged within 15 business days from receipt by the Plan.

Processing of Disputes

The Grievance Department collects all available information submitted by providers in support of their dispute. Provider disputes are recorded in a computer-based Dispute Log, which includes fields for provider name, date of occurrence, type of dispute, and disposition. Dispute information is submitted to the Grievance Committee, which meets weekly for dispute review and resolution.

Resolution of Disputes

The Grievance Committee will resolve each dispute or amended dispute and will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 business days after the receipt of the provider dispute or amended provider dispute. Copies of provider disputes and determinations, including all information upon which the Plan relied to reach its decision will be retained for five years.

Grievance Committee resolutions are reviewed quarterly by the Quality Improvement Committee.

Payment of Disputed Claims

If the resolution of the dispute involves payment to the provider for a disputed claim or claims, payment will be made within five working days after the date of the determination letter.

Dispute Resolution Process Oversight

The VP of Western Dental Plan is primarily responsible for the dispute resolution mechanism, for the review of its operations and for noting any emerging pattern of provider disputes to improve administrative capacity, plan-provider relations, claims payment procedures and patient care. The VP of Western Dental Plan is responsible for preparing reports and disclosures.

Western Dental SERVICES, INC.

PROVIDER DISPUTE FORM

Attn: Provider Relations
530 S. Main St., Ste 110
Orange, CA 92868
1-800-992-3366

PLEASE CONSULT THE GRIEVANCE DEPARTMENT FOR ASSISTANCE IN COMPLETING THIS FORM. Please return this form to the address listed above. You will receive a written response. This form may also be used by non-contracted providers.

Date of incident

Office Address, City, State, Zip

Provider Number (if applicable)

Patient's Name (if applicable)

Provider Name

Dental Plan #

Provider Phone #

Claim # **Member #**

DESCRIPTION OF DISPUTE (If the dispute is claims related, please include applicable claim number(s) and dates of service)

HOW WOULD YOU LIKE THIS MATTER RESOLVED?

Provider's Signature

Date

You can obtain information about the Plan's Provider Dispute Resolution Process in your Provider Guide or by calling 1-800-992-3366.

If a Grievance is Filed by a Patient of Your Office

You will be asked to:

- Provide a copy of the patient's complete dental record including x-rays and financial ledger within 5 business days.
- Provide a written response specific to the patient's concerns within 5 business days.
- Comply with the grievance committee findings and resolution.

How To Report a Provider Directory Inaccuracy

In an effort to comply with State requirements for providing an accurate provider directory, Western Dental Services now offers several easy ways to report a potential provider directory inaccuracy. The regulation requires WDS to verify and confirm with all contracted providers that their information is current and up to date. Notifications will be sent to all contracted providers every six months and will require an affirmative response within 30 days acknowledging the notification was received and information about any applicable changes to the data on file. To report any provider directory inaccuracies contact Provider Relations at **1-800-811-5111**, via email at ProviderDirectoryUpdate@westerndental.com or by using the online change form available by clicking the ***Provider Update*** link on our website, http://www.westerndentalbenefits.com.

XI.

QUALITY ASSURANCE

QUALITY ASSURANCE

The following section contains important information about appointment availability, wait times, patient care guidelines and the onsite review of your dental office.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION I – ACCESS AND AVAILABILITY	
I.F – Monitoring Appointment Availability	
QIC Chair:	Approved on:

I.F1 – MONITORING APPOINTMENT AVAILABILITY POLICY

It is the policy of Western Dental Services, Inc., ("WDS") to establish standards for access to routine dental services and specialty dental services. The Plan monitors its performance against the standards for appointment availability and takes action, if opportunities are identified for improvement, to assure that appointments are available to its enrollees.

If medically necessary covered services are not available within the Plan's network in accordance with the standards for appointment availability set forth below, the provider must contact WDS.

Access standards are communicated to all WDS providers via the Provider Manual, provider newsletters and provider mailings.

I.F2 – ROUTINE DENTAL SERVICES REQUIREMENTS

Standards for access to routine dental services are as follows:

*	Initial Appointment	within 3 weeks
*	Hygiene Appointment	within 3 weeks
*	Routine Appointment	within 3 weeks
*	Urgent Appointment	within 24 hours
*	Emergency Services	24 hours/day, 7 days/week, 365days/year
*	Waiting Room Time	less than 45 minutes

Standards for rescheduling appointments are as follows:

When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the requirements of this policy.

I.F3 – SPECIALTY DENTAL SERVICES REQUIREMENTS

Standards for access to specialty dental services are as follows:

*	Initial Consultation Appointment	within 3 weeks
*	On-going Care Appointment	within 3 weeks
*	Urgent Appointment	within 24 hours
*	Emergency Services	24 hours/day, 7 days/week, 365days/year
*	Waiting Room Time	less than 45 minutes

Standards for rescheduling appointments are as follows:

When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the requirements of this policy.

I.F4 – REPORTING REQUIREMENTS

The Quality Management Department and the Provider Relations Department provide monthly, quarterly and annual access and availability reports to the Utilization Management Committee ("UMC"). The following reports are generated on a monthly, quarterly or annual basis, as noted, and are reviewed by the UMC for compliance with appointment availability and wait time standards:

- Provider Appointment Access Survey (Initial, Hygiene, Restorative), Monthly
- Grievance Report (Categories of Wait Time, Access to Appointments, Facility Location, Emergency Access Specialty Referrals), Quarterly
- Emergency Access Survey (Includes random calls made after-hours and the follow-up completed for offices out of compliance), Monthly
- Emergency Access Satisfaction Survey, Quarterly
- Specialty Referral Report, Quarterly
- Facility Audits Report, Annually
- Customer Satisfaction Survey Report, Annually
- Provider Survey Report, Annually
- Wait Time Outlier Report, Monthly

I.F5 – ACCESSIBILITY TO CUSTOMER SERVICE

Standards for access to WDS customer service are as follows:

During normal business hours (Monday through Friday, 8:30 AM to 5:00 PM), the waiting time for an enrollee to speak by telephone with a WDS customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

QUALITY ASSURANCE
PATIENT CARE GUIDELINES

Western Dental Services, Inc., ("WDS") considers the following guidelines to be its minimum acceptable standards for patient care:

EMERGENCY CARE

ACCESS

- Please see the Policies and Procedures section of this Provider Guide for all access requirements.
- 24-hour emergency telephone access (e.g., cellular phone, answering service, recorded message with a pager or cellular phone number provided) must be available.
- When necessary for the condition of the patient, the patient must be seen within 24 hours after the patient calls and informs the office of an emergency situation.
- Language assistance must be available for all patients needing translation or interpretation services. Please refer to the Language Assistance section of this Provider Guide.

RADIOGRAPHS AND OTHER IMAGING

- Bitewing and/or periapical of area(s) of concern should be taken, whenever possible. If available, a photograph or a panoramic radiograph should be taken when 1) conditions make intraoral films impossible to take or 2) when intraoral films will not be diagnostic of the suspected condition.
- Refusal of radiographs and any discussion should be documented in the chart.

DIAGNOSIS AND TREATMENT

- At emergency visits, whenever possible, a soft tissue exam should be completed and documented.
- Definitive treatment for the emergency condition should be provided whenever possible. In instances in which it is not possible or when referral to a specialist is necessary, appropriate palliative treatment or medications should be provided to stabilize the condition and/or alleviate symptoms, as needed.
- Acute and emergency problems should be sequenced before comprehensive or routine dental treatment.

NEW PATIENT PROTOCOL AND DOCUMENTATION

ACCESS

- Please see the Policies and Procedures section of this Provider Guide for all access requirements.

- Initial exam appointments should be available as soon as is reasonable to address the needs of the patient in a timely manner and, in all circumstances, must be available within three weeks from the time of contact.
- Waiting time in the reception area should not exceed 45 minutes. This includes the time necessary to complete paperwork such as the registration forms and the Medical History. Although waiting time should be minimized for all patients, this waiting time guideline may not be applicable for walk-in patients or unplanned emergency visits.
- Language assistance must be available for all patients needing translation or interpretation services. Please refer to the Language Assistance section of this Provider Guide.

DOCUMENTATION

Complete patient records, including radiographs and other imaging, must be kept for a minimum of 5 years. (Note – there may be other applicable times for record retention for risk management purposes).

Paper Records. Ink should be used for all chart entries, rather than pencil. Full signatures of the treating dentist or licensed auxiliary who is responsible for the treatment must be present or initials and identifying numbers (e.g., state license number). Corrections should be made with a single strike-through line so that the original entry can still be read. A note should be made to identify the correction and describe the reason for the correction, and the note should be signed and dated with the date the correction was made.

Electronic Records. There must be a system in place for a provider signature and time stamp/date to authenticate chart entries (typically a login/password protected mechanism). There must also be a system that ensures chart entries cannot be altered after authentication/saving in a manner that would conceal the change.

At all initial examinations (non-emergency), the following should be performed and documented in the patient chart:

- At the initial visit or at the first subsequent visit at which it would be reasonable to do so, a Comprehensive Examination should be performed for all patients (adults and children) and documented in the chart. If a patient objects to a comprehensive examination, the objection and any discussion should be documented in the chart.
- Appropriate radiographs based on a clinical examination and the FDA/ADA guidelines should be taken. For film radiographs, the current radiographs must be mounted with the patient's name and the date the x-rays were taken. It is advisable to also include the name and address of the dentist on the radiograph holder. Refusal of radiographs and any discussion should be documented in the chart.

- Bitewing radiographs should not be overlapped and should show the contacts of the relevant teeth. The occlusal plane should be centered horizontally and the crestal bone should be visible, except in severe periodontal cases.
- Periapical radiographs should show the apices of all relevant teeth.
- Full mouth radiographs are generally necessary (typically 18 total: 4 bitewings, 6 anterior periapicals, 8 posterior periapicals) on patients with mild or greater chronic adult periodontitis and on patients with other generalized dental disease and/or a history of extensive dental treatment.
- If available, photographs or a panoramic radiograph should be taken when 1) conditions make intraoral films impossible to take or 2) when intraoral films will not be diagnostic of the suspected condition.
- A thorough Medical History must be completed and present in the record. It should contain questions regarding general health status, relevant diseases/conditions (including reactions to dental anesthetics, latex allergy and bisphosphonate use), allergies, and medications taken. The medical history should be in a "yes or no" format. The name and number of the patient's physician should be present. The medical history must be dated and signed by the patient/responsible party and the dentist.
- The dentist should initial and write/enter comments next to all significant positive responses in the medical history. When necessary, there should be documentation to evidence that the patient was referred for physician evaluation and recommendation when the patient's physical status was questionable or other significant conditions appeared to be present.
- Medical Alert Stickers are necessary when the medical condition is relevant to dental treatment.
    - Stickers appearing on a paper chart jacket must <u>not</u> contain any medical information, unless the condition could lead to a life-threatening situation during dental care (e.g., latex or penicillin allergy). Stickers appearing within the chart may contain medical information.
    - Electronic records must have a medical alert system that requires the dentist to evidence his/her review at each visit or that displays on all chart pages.
    - It may not be appropriate to display medical information on a sticker/alert screen within either paper or electronic charts for the following conditions: alcoholism, substance abuse, HIV status, AIDS, or any psychiatric disorder.
- The Chief Complaint should be noted in the chart.
- It is recommended that a Blood Pressure Measurement be taken on all adults. At a minimum, blood pressure must be taken on all adult patients when necessary for patient safety due to a related item in the patient's medical history. Routine blood pressure measurement on children is also recommended, but must be taken when necessary for patient safety due to a medical condition.
- It is recommended to collect the Date of Last Dental Visit and the Date of Last Dental X-rays. To minimize exposure to radiation, bitewing radiographs taken within the last year and full mouth or panographic radiographs taken within the last 3 years should be obtained from the previous dentist, whenever possible.

- Documentation of Existing Restorations should be recorded on a tooth-grid chart or in another format, such as with photographic images. It is recommended that the documentation include age and condition of existing fixed and removable appliances.
- A Periodontal Evaluation must be performed for all patients. Indicators, such as the oral hygiene status, gingival status, and pocket depths (based on minimal probing and screening) are acceptable measures of the patient's condition at the time of the initial exam and should be recorded. Full-mouth pocket charting should be present for all patients who have periodontal disease.
- A Soft Tissue/Oral Cancer Exam of the head, neck, mucosa, palate, tongue, pharynx, and floor of the mouth should be performed and recorded.
- A TMJ or Occlusion Analysis should be performed and documented.
- A written Treatment Plan should be present.
- A written Informed Consent form should be present and should contain descriptions of the common risks and benefits of each treatment type planned for that patient. If the form calls for initials of the patient for each treatment type, the patient's initials should be in applicable treatment areas and not in inapplicable areas. The patient's and dentist's signatures and date must also be present. A "general consent" that does not list individual procedure types (crowns, endodontics, fillings, etc.) does not meet the guidelines.
- A written narrative should provide additional relevant diagnostic findings, such as the need to place or replace restorations in instances where pathology is not evident in radiographs or the reasons for replacement of current prostheses.

DIAGNOSIS AND TREATMENT PLAN

All pathologic or abnormal conditions should be identified and diagnosed. The treatment plan should include any recommendation necessary for each diagnosed condition (including treatment plans to "observe"). All applicable alternative treatments should also be listed or noted as offered.

Preventive Services

- When appropriate, preventive treatments should be recommended to decrease the likelihood of further dental disease. Preventive treatments may include prophylaxes, fluoride applications, sealants, chemical interventions, dietary guidance and home care instructions.
- There should be documentation that a prophylaxis was performed in a timely manner (for any patient who is planned for prophylaxis). The frequency and type of prophylaxis is dependent on the patient's rate of plaque and calculus formation and caries susceptibility.
- Children at moderate or high susceptibility for caries should receive fluoride treatments and pit and fissure sealants at appropriate intervals and timing per the current guidelines of the American Academy of Pediatric Dentistry.
- Mature adults who are at moderate, high or very high susceptibility for caries should receive fluoride treatments, chemical interventions, dietary guidance, and specialized home care products/techniques.

- All preventive measures recommended should be documented in the chart. If a patient/responsible party refuses preventive treatments, the refusal and any discussion should be documented in the chart.
- Oral Hygiene Instructions should be planned for each patient, and OHI should be provided at the initial, prophylaxis or other maintenance appointment, and documented in the progress notes.
- Documentation of guidance provided for cessation of smoking and other harmful habits is recommended.

Restorative Services

- All teeth requiring restorative services should be treatment planned accordingly. Minimally invasive techniques may be planned where appropriate to address caries.
- Need for planned restorative treatments should be evident in the radiographs or should be supported by documentation. This documentation may include photographic or other imaging, caries detection results, or documentation of the clinical conditions. It is recommended that a caries risk assessment be completed to establish background for restorative decisions regarding invasive treatments.

Endodontics

- There should be evidence of the need for all planned endodontic treatments. Endodontic treatments for which the need is <u>not</u> evident in the radiographs should be supported by documentation. This documentation may include the history and current status of the tooth with regards to pain, swelling, pulpal exposure, mobility and thermal sensitivity. Results of pulp testing should also be recorded (thermal test, percussive tests, electric pulp test, etc.).
- Rubber dam isolation should be used and documented for all endodontic treatment.

Periodontal Treatments

The current Periodontal Classifications are as follows:

Gingival Disease: Inflammation of the gingiva, characterized clinically by gingival hyperplasia, edema, retractability, gingival pocket formation and no bone loss. May be plaque induced or non-plaque induced, localized or gereralized.

Chronic Periodontitis: Common, long-standing, usually with a slow progression. May be localized or generalized

- Slight – early bone loss with slight pocket formation (up to 4 mm)
- Moderate – bone loss with moderate pocket formation (up to 6 mm)
- Severe – advanced bone loss with deep pocket formation (> 6 mm)

Aggressive Periodontitis: May be early-onset or rapidly progressing; the amount of microbial deposits may be inconsistent with the severity of the disease. May be localized or generalized.

Periodontal Scaling and Root Planing:

- Periodontal scaling and root planing (PSRP) is indicated for patients with Chronic Periodontitis or Aggressive Periodontitis. Full-mouth periodontal charting must be documented prior to any PSRP procedure.
- When PSRP is performed, local anesthetic is usually necessary. The use of local anesthetic, topical anesthetic or no anesthetic should be documented.
- Rationale for more than two quadrants of PSRP at a visit should be documented.

Prosthetic Services (including Implant Prosthetics)

- The conditions of any existing prosthetic appliance should be documented.
- The rationale for new prosthetics should be obvious in the radiographs or documented in the chart.

Oral Surgery

- The rationale for any oral surgery procedure should be obvious in the radiographs or should be documented in the chart.
- Extraction coding – Refer to the most recent edition of the ADA Current Dental Terminology for explanation of proper extraction coding. The category of extraction noted should be supported by the radiographic and clinical documentation.
- The description of an extraction procedure should also support the category noted (e.g., the raising of a flap and the removal of bone or sectioning of the tooth should be noted when a surgical extraction is performed).

Sequencing

- The **treatment plan** must be sequenced and in proper order (see example below):

1. Relief of pain and discomfort
2. Elimination of infection, irritations, traumatic conditions
3. Prophylaxis and instruction in preventive practices
4. Treatment of extensive carious lesions and pulpal inflammation
5. Periodontal treatment
6. Elimination of remaining caries, necessary extractions
7. Restoration and replacement of teeth
8. Placement of the patient on a recall schedule to suit the assessed needs

Referrals to Specialists

- The rationale for referrals to specialists should be documented in the chart.
- Referrals should be made in a timely manner as part of a rational sequence.
- Referrals made as a result of unplanned events encountered during treatment should be made as expediently as necessary to avoid deterioration of any unstable conditions.

PROGRESS NOTES

- All teeth numbers of treated teeth, procedures performed, materials and medicaments used should be recorded in the progress notes.
- The progress notes in a paper record must be signed by the treating dentist using either a full signature or initials with an identifying number. In an electronic record, each progress note must be authenticated with electronic date automatically generated.
- When prescribing antibiotics and other medications, the rationale for the prescription should be clearly written in the patient chart if the need for such medication is not implied (e.g., the need for pain medication following an oral surgical procedure is implied).
- Prescription notations should include the strength of the medication prescribed, number of tablets/capsules/cc's, and the instructions for taking the medication (the "SIG"). To ensure appropriate prescribing of medications, it is recommended that the rationale for prescribing opioid pain relievers and antibiotics that is not obvious be documented in the chart.
- Local anesthesia should be documented appropriately, including the number of cartridges used or the number of milliliters given, the name and concentration of the anesthetic agent and the concentration of vasoconstrictor. For example: *1 cartridge 2% lidocaine 1/100,000 epi* (also written as 1 x 10-5 or 1/100K, but not written as 1/100). Documentation should also be made when anesthetic is not used for procedures that would normally require anesthesia.

TREATMENT OUTCOMES

- The outcomes of treatments should meet the accepted standards for care, whenever possible. For treatments where an acceptable outcome was not possible or was not in the best interest of the patient, the reason should be documented (e.g., root tip left because of likelihood of significant morbidity associated with access and removal)
    - Restorative treatments – margins, contours, occlusion and contacts should be acceptable; esthetics should be acceptable to the patient/responsible party
    - Endodontic treatments – for RCTs all accessible canals are cleaned, shaped and obturated with absence of voids in the apical one-third; obturant extends within 1 mm of canal terminus and is not overextended more than 1 mm past canal terminus
    - Prophylaxis and periodontal treatments – tartar and plaque are removed from all accessible crown and root surfaces
    - Prosthetic services – treatment was completed timely, including necessary adjustments; form and function were restored; esthetics should be acceptable to the patient/responsible party; implants placed should show evidence of osseointegration after an appropriate time
    - Oral surgery treatments – for extractions the entire tooth is removed with reasonably minimal effects on adjacent structures; post-operative

instructions and post-operative care were provided; need for post-operative care was not excessive

- In the event of an untoward outcome, there should be documentation that demonstrates 1) the patient/responsible party was informed of the outcome and 2) any appropriate corrective treatment or observation is planned.

RECALL PATIENTS

ACCESS

- Please see the Policies and Procedures section of this Provider Guide for all access requirements.
- Recall patients must be scheduled for an appointment within 3 weeks of contact.
- Waiting time in the reception room should not exceed 45 minutes (except when necessary for patients returning on a walk-in or emergency basis).
- Language assistance must be available for all patients needing translation or interpretation services. Please refer to the Language Assistance section of this Provider Guide.

DOCUMENTATION

- Medical history updates and follow-up to health problems should be performed at least annually or sooner if there is a change in health status. The doctor and patient should sign the updated medical history.

PROPHYLAXIS/PERIODONTAL MAINTENANCE

- **Patient without Periodontal Disease.** Typically, the patient should be seen every 6 months to one year for prophylaxis and periodontal evaluation, as appropriate for the patient's level of risk for caries and periodontal disease.
- **Periodontal patient.** Usually the patient should be seen for periodontal maintenance every 3 to 6 months, or sooner when necessary, with full-mouth pocket charting documented every 6 to 12 months, depending on the current disease activity state.

RADIOGRAPHS

- Appropriate recall radiographs based on a clinical examination and the FDA/ADA guidelines should be taken. For film radiographs, the current radiographs must be mounted with the patient's name and the date the x-rays were taken. It is advisable to also include the name and address of the dentist on the radiograph holder. Refusal of radiographs and any discussion should be documented in the chart.
- A full series of radiographs should generally not be taken more frequently than within three years of the last FMX, unless unusual conditions are present.

STERILIZATION REQUIREMENTS

- Sterilization and infection control protocols must be conspicuously posted.
- A functioning sterilizer (steam, chemical vapor, or rapid dry heat) must be used in the office.
- Weekly biological testing must be performed on each sterilizer present in the office (including any sterilizer that is kept as a back-up), with the results on file and readily available upon request (for a minimum of 12 months). Corrective action must be taken on failed tests and must be documented.
- All instruments, including handpieces and burs, must be properly cleaned, bagged, and sterilized between patients. All sterilization bags must be dated, must not show signs of moisture or stains, and they must remain intact and unopened until ready for patient use. At that time, they should be opened in front of the patient. Once a bag is opened, all instruments within the bag must be rebagged, dated and resterilized, regardless of whether or not they were used. The packages should be stored in drawers or cabinets with doors.
- Instruments that cannot be cold-sterilized or autoclaved must be disposable.
- Chemical disinfectants ("cold sterilization" solutions) must contain an EPA approved cold-sterilant (high level disinfectant) tuberculocidal hospital disinfectant, utilized according to the manufacturer's recommendations for sterilization. Solutions must be changed when the solution becomes cloudy or burdened with particulates, but in no instance later than the manufacturer's recommended expiration date. A log must be kept that indicates the name of the solution used, the date that the solution was changed and the new expiration date.
- All operatory and work surfaces, including computer keyboards in operatories, must be disinfected with a Cal OSHA/EPA approved solution between patients or covered with impervious materials.
- Operatory water lines must be flushed for two minutes in the morning before use and for 20 seconds between each patient. Water lines must have anti-retraction valves.
- Proper rinsing and disinfection of impressions and dentures must be performed routinely. Laboratory burs and non-disposable rag wheels must be sterilized between contaminated cases. Pumice must be changed after each use.

INFECTION CONTROL PROTECTION

- Nitrile or heavy utility gloves must be used when cleaning instruments.
- Personal protective equipment such as masks, gloves, protective eyewear, and long sleeve lab coats must be worn when treating patients. Splattered or soiled garments should be replaced as necessary. Masks must be changed between patients or when visibly soiled while treating the same patient. Gloves must be changed between patients and before leaving the operatory.
- All sharps must be placed in a sharps container. A sharps container should be located in each operatory. A registered medical waste hauler must be used for proper disposal and tracking documents must be kept on file.

OTHER REQUIREMENTS

- The facility and equipment should be clean, safe and in good repair. There should be no visible stains or significant scarring of furniture or floors. There should be no debris on floors in patient treatment, reception, infection control areas and laboratories. Lighting should be sufficient to allow safe ingress and egress and to maintain good vision. Dental equipment should be appropriate and in good working condition (free from obviously broken parts, visible damage, temporary repairs or grossly torn upholstery).
- When taking x-rays, a lead apron with a thyroid collar must be used.
- All x-ray units must be registered with the State and such documentation must be available upon request.
- All personnel taking x-rays must be certified and copies of the certificates must be prominently displayed.

HAZARDOUS MATERIALS PROTOCOL

- All amalgamators must have attached covers.
- Use of amalgam capsules is recommended.
- Used or scrap amalgam waste products must be kept in a tightly covered non-breakable container.
- A mercury spill kit must be present.
- Dispose of hazardous materials, including scrap amalgam waste products, according to state and local guidelines. A registered hazardous waste hauler must be used for materials such as scrap amalgam, scrap lead from x-ray film, used fixer and developer solutions, and used sterilization solutions.
- If present, nitrous oxide equipment must be clean, safe and in good repair. A recovery system with connection to exhaust or suction system must be present and used. A failsafe system must be present and functioning for delivery of gases.

EMERGENCY PROTOCOL

- A portable oxygen supply or an ambu-bag must be present and available. Staff should be aware of the location and the operation of the emergency oxygen/ambu-bag. It is recommended that a minimum of one oxygen tank be kept full at all times to have adequate oxygen available if needed.
- A medical emergency kit must be present. It must minimally include the following drugs: injectable epinephrine, injectable benadryl, nitroglycerine, albuterol inhaler, sugar source, non-diet soda or orange juice, chewable aspirin. All drugs present must be current. The kit, along with the emergency oxygen supply, must be readily available to all persons working in the office.
- Fire, police and 911 numbers must be posted in the office.

- Office evacuation routes must be posted. Exits must be clearly marked. Written protocol for evacuation procedure must be available.

SPECIALTY REFERRAL

- See Specialty Referral Guidelines.
- All Specialty Referral requests must be preauthorized using a referral form, unless situation requires emergency referral. In emergency cases authorization must be obtained over the telephone by calling WDS at 1-800-992-3366.
- Chronic and non-emergency cases require timely completion of and submission of a Specialty Referral Form.
- Offices must follow-up to specialty referrals to ensure continuity of care.

GENERAL DENTIST
STRUCTURAL REVIEW

(Facility Review Form)

GENERAL DENTIST STRUCTURAL REVIEW

«Office_Name»
«Address1»
«Address2»
«City», «State» «Zip»
«Telephone»

PBG#: «PBG» Audit Date: _____ Auditor: «Auditor»

NPI Number: _____ Email:_____

Change of Address: ☐Yes ☐No ☐Second Review/Focused Audit

I. ACCESSIBILITY

U	N/A		NOTES:
☐	☐	453. 24 Hour Emergency Contact System	
☐	☐	454. Reasonable appointment scheduling for plan members	
☐	☐	600. Language Assistance Program and Documents	
Check: ☐Arabic ☐Armenian ☐ Bengali ☐Cantonese/Mandarin ☐Farsi/Persian ☐German ☐French ☐Hindi ☐Korean ☐Russian ☐Spanish ☐Tagalog/Filipino ☐Simplified Chinese ☐Khmer ☐ Hmong ☐Lao ☐ Vietnamese ☐English Only ☐Other non-English (List in notes)			

II. FACILITY AND EQUIPMENT

U	N/A		NOTES:
☐	☐	455. Clean, safe, neat and well maintained	
☐	☐	456. Compliance with mercury hygiene, safety regulations	
☐	☐	457. Nitrous Oxide recovery system	
☐	☐	458. Lead apron (with thyroid collar) for patient	

OFFICE NAME: «Office_Name1» PBG#: «PBG1» AUDITOR: «Auditor1»

III. EMERGENCY PROCEDURES AND EQUIPMENT

U	N/A		NOTES:
☐	☐	459. Written emergency protocols	
☐	☐	460. Medical emergency kit on-site	
☐	☐	461. Portable emergency oxygen available	

IV. STERILIZATION AND INFECTION CONTROL

U	N/A		NOTES:
☐	☐	462. Sterilization and infection control protocols followed	
☐	☐	463. Protocols posted for sterilization procedures	
☐	☐	464. Weekly biological (spore) monitoring of all sterilizers	
☐	☐	465. All instruments and hand-pieces properly cleaned, sterilized and stored	
☐	☐	466. Log kept monitoring changing of sterilization solutions	
☐	☐	467. Staff wears appropriate personal protective equipment	
☐	☐	468. Proper and adequate use of barrier techniques	
☐	☐	469. Hand-pieces and waterlines flushed and disinfected appropriately	
☐	☐	470. Infection control and cross contamination prevention procedures followed in the office and the laboratory	

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

GENERAL DENTIST PROCEDURAL REVIEW

(Chart Review Form)

GENERAL DENTIST PROCEDURAL REVIEW

(PLEASE REVIEW 10 CHARTS)

OFFICE NAME: «OFFICE_NAME2» PBG#: «PBG2» AUDITOR: «AUDITOR2»

CHARTS: (LAST NAME, FIRST NAME) PRINT LEGIBLY

1)_____ 2)_____ 3)_____ 4)_____ 5)_____

6)_____ 7)_____ 8)_____ 9)_____ 10)_____

	1	2	3	4	5	6	7	8	9	10	Notes:
	Please enter U or N only										
I. DOCUMENTATION											
A. Medical History											
1. Comprehensive information collection											
2. Medical follow-up											
3. Appropriate medical alert											
4. Doctor signature and date											
5. Periodic update											
B. Dental History/Chief Complaint											
1. Dental History/Chief Complaint											
C. Documentation of Baseline Intra/Extra Oral Examination											
1. Status of teeth/existing conditions											
2. TMJ/Occlusion evaluation											
3. Prosthetics											
4. Status of periodontal condition											
5. Soft tissue/oral cancer exam											

ACCEPTABLE RATING: LEAVE BLANK. ENTER "N" FOR NOT APPLICABLE & CANNOT EVALUATE. ENTER "U" FOR UNACCEPTABLE

OFFICE NAME: «OFFICE_NAME3» PBG#: «PBG3» AUDITOR: «AUDITOR3»

	1	2	3	4	5	6	7	8	9	10	Notes:
	Please enter U or N only										
D. Progress Notes											
1. Legible and in ink											
2. Signed and dated by provider											
3. Anesthetics notes											
4. Prescriptions noted											
II. QUALITY OF CARE											
A. Radiographs											
1. Quantity/frequency											
2. Technical quality											
3. Mounted, labeled and dated											
B. Treatment Plan											
1. Present and in ink											
2. Sequenced											
3. Informed consent											
III. TREATMENT OUTCOMES OF CARE											
A. Preventive Services											
1. Diagnosis											
2. Oral hygiene instructions											
3. Recall											
B. Operative Services											
1. Diagnosis											
2. Restorative outcome and follow-up											
3. Specialist Referral											

ACCEPTABLE RATING: LEAVE BLANK. ENTER "N" FOR NOT APPLICABLE & CANNOT EVALUATE. ENTER "U" FOR UNACCEPTABLE

OFFICE NAME: «OFFICE_NAME4» PBG#: «PBG4» AUDITOR: «AUDITOR4»

	1	2	3	4	5	6	7	8	9	10	Notes:
	Please enter U or N only										
C. Crow n and Bridge Services											
1. Diagnosis											
2. Restorative outcome and follow-up											
3. Specialist referral											
D. Endodontic Services											
1. Diagnosis											
2. Rubber dam use											
3. Endodontic outcome and follow-up											
4. Specialist referral											
E. Periodontic Services											
1. Diagnosis											
2. Treatment per visit											
3. Periodontal follow-up/outcome											
4. Specialist referral											
F. Prosthetic Services											
1. Diagnosis											
2. Prosthetic outcome and follow-up											
3. Specialist referral											
G. Surgical Services											
1. Diagnosis											
2. Surgical outcome and follow-up											
3. Specialist referral											
H. Overall Patient Care											
1. Overall care meets professional standards											

ACCEPTABLE RATING: LEAVE BLANK. ENTER "N" FOR NOT APPLICABLE & CANNOT EVALUATE. ENTER "U" FOR UNACCEPTABLE

COMMENTS:

ATTACH BUSINESS CARD HERE

Medical Emergency Kit For General Dentistry

An **emergency kit** should be maintained and the drugs contained within should be updated periodically. The basic kit should include the following items:

- Bronchodilator/Albuterol
- Epinephrine
- Aspirin
- Nitroglycerin or Amylnitrate
- Aromatic Ammonia
- Antihypoglycemic Aids/Orange Juice
- Glucose (I.V.) 50m150% dextrose
- Oxygen
- Injectable Histmaine - Blocker/Diphenhydramine HCI

XII.

PROVIDER DIRECTORY GUIDELINES

PROVIDER DIRECTORY GUIDELINES

The following section contains important information about regularly updating your provider information with WDS in order to maintain provider directory accuracy.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION I – ACCESS AND AVAILABILITY	
I.J – Provider Directory	
UM Chair:	Approved on:
QIC Chair:	Approved on:

I.J1 – PURPOSE

To describe the processes by which Western Dental Services, Inc. ("WDS" or the "Plan") provides enrollees, prospective enrollees, the general public, and providers with the most current and accurate information regarding its network of contracting primary care providers, dental groups, and independent practice associations (collectively referred to as "providers") through the Plan's electronic and print Provider Directories (the "Directory" or "Directories"). This policy ensures that accurate participating provider network information is made available for each WDS network and product offering.

I.J2 – POLICY

The Plan shall establish and maintain processes to ensure:

1. Its Directory is updated on a regular basis, including required weekly, quarterly, and annual updates;[1]

2. That providers may promptly submit and verify changes to Directory information;[2] and

3. That there is a process by which enrollees, potential enrollees, other providers, and the public may identify and report possible inaccurate, incomplete, or misleading information in the Plan's Directory.[3]

In developing and maintaining its Directories, the Plan will comply with all Section 1367.27 of Knox-Keene Health Care Service Plan Act of 1975 and all regulations promulgated thereunder, including the Uniform Provider Directory Standards (effective 01/01/2018) issued by the Department of Managed Health Care (the "Department" or "DMHC") and any subsequent provider directory standards.[4]

I.J3 – SCOPE

The provider directory policies and procedures apply to both WDS staff model and network providers.

I.J4 – PROVIDER NOTICE AND VERIFICATION

1. **Obtaining Initial Provider Information.** Provider information shall initially be obtained from the provider via e-mail, mail, and telephone per the WDS credentialing process. All information shall be entered into the WDS Benefits IT system. The provider information provided to WDS will be verified per the WDS credentialing process, which includes in house verification of data with various state and federal agencies, secret shopper calls, and the utilization of Credential Verification Organization.

[1] H&S § 1367.27(m).
[2] H&S § 1367.27(m)(2).
[3] H&S § 1367.27(m)(3).
[4] H&S § 1367.27(k)(3).

2. **Provider-Initiated Updates.** Providers may submit updates to their information listed in the Directory at any time by submitting their completed form by:

   a. Mail: Provider Relations, 530 S. Main St. Orange, California, 92868

   b. Fax: 714-571-3650;

   c. Email: ProviderDirectoryUpdate@westerndental.com; or

   d. Online: https://westerndentalbenefits.com/providerdiscrepancy/Default.aspx.

      i. When a provider submits an update using the online interface, the interface shall generate an acknowledgement of receipt form the Plan.[5]

   e. If a provider has questions about the credentialing or updates to the Directory, they may also call the Plan at 1-800-811-5111.

3. **Semi-Annual Provider Notification.** Every six months WDS sends individual and group contracted providers a mailing to obtain confirmation of current provider and facility data as published in the Directory.[6]

   a. Notice Content. When contacting the providers, the Plan shall notify the provider or provider group of:

      i. **Currently Listed Information.** The information the Plan has listed in tis Provider Directory for the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group;[7]

      ii. **Consequences of Failing to Respond.** A statement that the failure to respond to the notice may result in a delay of payment or reimbursement of a claim;[8] and

      iii. **Instructions on Updating Information.** Instructions on how the provider or provider group can update the information in the Plan's Provider Directory using the Plan's online interface.[9]

   b. Required Affirmative Response. Providers/provider groups are required to provide an affirmative response that they received the above notification and either[10]

      i. Confirm that the information listed in the Provider Directory is current and accurate; or

      ii. Provide updated information.

   c. Failure to Respond. All contracted providers are required to affirm receipt of notification within thirty (30) business days. WDS shall take no more than fifteen (15) business days to verify the information of a notified provider who does not respond within thirty (30) business days. The Plan shall document the receipt and outcome of each attempt to verify the provider's Directory information.[11]

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[5] H&S § 1367.27(m)(2).
[6] H&S § 1367.27(l)(1)(A).
[7] H&S § 1367.27(l)(2)(A).
[8] H&S § 1367.27(l)(2)(B).
[9] H&S § 1367.27(l)(2)(C).
[10] H&S § 1367.27(l)(3).
[11] H&S § 1367.27(l)(4).

d. Delay in Reimbursement. A provider's failure to respond to the Plan's attempt to verify provider's information listed in the Directory may result in a delay of the provider's claim reimbursement for up to one (1) calendar month beginning on the first day of the following month, and/or a delay of fifty (50) percent of the next scheduled capitation payment for up to one (1) calendar month.

i. **Required Notice Prior to Delay.** The Plan shall only delay payment or claim reimbursement after providing the provider ten (10) business days' notice of that the provider has failed to confirm or update provider's information required to be listed in the Directory, as requested by WDS in writing, electronically, and by telephone.

ii. **Length of Delay.** If payment is delayed pursuant to this section, WDS shall reimburse the full amount of any payment subject to delay:

(1) No later than three (3) business days following the date on which the Plan receives the information required herein to be submitted by provider; or

(2) At the end of the one-(1) calendar month delay if the provider fails to provide the required information.

e. Unable to Verify. If the provider failed to respond and the Plan is unable to verify the provider's Directory information, WDS shall notify the provider of pending directory removal ten (10) business days prior to removal.[12] If the provider has not responded by the end of such ten-day notice period, the Plan shall remove the provider as part of the next scheduled update to the Directory.[13]

4. **Quarterly Internal Review.** Provider licensure and contracting status for providers shall be monitored and maintained via the Benefits IT system and the WDS ongoing credentialing process, which includes in house verification of data with various state and federal agencies, secret shopper calls, and the utilization of Credential Verification Organization to ensure the accuracy of such data. On at least a quarterly basis, WDS' Provider Relations staff will review the provider directory and verify the status of licensure and insurance for expiration. Changes to required information shall be implemented in the next scheduled weekly Directory update.

a. License Verification. Each provider's license is verified through the Department of Consumer Affairs license search at https://search.dca.ca.gov/.

I.J5 – DIRECTORY INACCURACIES

1. **Reporting Inaccuracies.** Enrollees, providers, and the public can report potential Directory inaccuracies by calling the Plan at (800) 992-3366 (for members) or (800) 811-5111 (for non-members), emailing ProviderDirectoryUpdate@westerndental.com, or via online form at https://westerndental.com/en-us/about-us/contact-us/submit-a-grievance (for members) or https://westerndentalbenefits.com/nonmemberdiscrepancy/Default.aspx (for non-members). The Plan's Print and Online Directories prominently display the Plan's dedicated email address and telephone number for reporting inaccuracies.[14]

[12] H&S § 1367.27(l)(4).
[13] H&S § 1367.27(l)(4).
[14] H&S § 1367.27(f).

2. **Investigating Inaccuracies.** Within thirty (30) business days of receiving a report of a potential Directory inaccuracy from an enrollee or potential enrollee, the Plan shall promptly investigate, and, if necessary, undertake corrective action. When investigating a reported inaccuracy, the Plan shall:

   a. Acknowledge the Report and Create a Tracking Ticket. Within one (1) business day of receiving a report, the Plan shall acknowledge the report and create a tracking ticket.

   b. Notify the Provider. Within no more than five (5) business days of receiving such report, the Plan shall contact the affected provider.[15]

   c. Investigate the Inaccuracy. The data in the system will be reviewed against the inaccuracy reported.

      i. If the report can be addressed internally, the Plan shall update the system and implement the change in the next weekly Directory update.

      ii. If the report is not resolved after internal review, the provider or group administrator shall be notified of the inaccuracy reported and required to respond within 5 days.

      iii. **If the Provider or group administrator fails to respond or address the inaccuracy reported within the required time, the directory entry in question shall be listed as inactive on the next scheduled weekly update or the update immediately following.**

   d. Document the Investigation. The Plan shall document the receipt and outcome of each report, including:[16]

      i. The provider's name and location;

      ii. A description of the plan's investigation;

      iii. The outcome of the investigation; and

      iv. Any resulting changes or updates made to its Directories.

   e. Update the Directory. The Plan shall implement any required changes to the Directory by no later than the next scheduled weekly update, the update immediately following that, or sooner if required by federal law or regulations.17

3. **Grievances Involving Discrepancies with the Provider Directory.** All grievances involving discrepancies between the provider directory and the providers' current contracting status shall be addressed through and documented in the Grievance and Appeals process. In circumstances where WDS' Grievance Committee finds that an enrollee reasonably relied upon materially inaccurate, incomplete, or misleading information contained in WDS' provider directory, WDS' Grievance Committee will find in favor of the enrollee and will direct WDS to provide such enrollee with appropriate coverage.

[15] H&S § 1367.27(o)(2)(A).
[16] H&S § 1367.27(o)(2)(B).
[17] H&S § 1367.27(o)(2)(C).

I.J6 – DIRECTORY UPDATES

1. **Weekly Directory Updates.** The online Directory is updated at least weekly to reflect any of the following changes:[18]

    a. A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients;

    b. A provider is no longer under contract for a particular plan product;

    c. A provider's practice location or other required information has changed;

    d. A change is required pursuant to an investigation of an enrollee complaint or report of an inaccuracy in the Directory; or

    e. Any other information that affects the content or accuracy of the Directory.

2. **Removing a Provider** Providers will be removed from the Directory when the Plan receives confirmation that:[19]

    a. The provider is deceased, retired, or otherwise ceased to practice;

    b. The provider or provider group is no longer under contract with the Plan; or

    c. The contracting provider group has informed the Plan that the provider is no longer associated with the provider group and is no longer under contract with the Plan.

3. **Correcting Reported Inaccuracies.** When the Plan determines that a change to the Directory is required following an investigation of a reported inaccuracy, the required changes shall be implemented in the next scheduled weekly update, the update immediately following that, or sooner if required by federal law or regulations.[20]

I.J7 – DIRECTORY ACCESS & CONTENT

1. **Notices of Directory Availability.** The "Choice of Provider" section of all WDS Evidence of Coverage booklets ("EOC") shall inform members of the Provider Directory along with the WDS contact telephone number for members who require assistance. Information regarding Provider Directories shall also be included in the Member Newsletters and on the WDS internet website.

2. **Online Directory.** An electronic version of the Directory (the "Online Directory") is accessible on the Plan's website homepage via an identifiable link which appears when clicking on or hovering over "Insurance & Financing.[21] Members and prospective members can view the online directory via the Western Dental website by choosing their current or prospective WDS Plan and the geographic area in which they are looking for a provider. Members can refer to their WDS ID card or call the WDS toll-free number to determine which Plan they are on. A prospective member (non-enrollee) can call the WDS toll free number and inquire as to which WDS plans his or her employer offers. The online provider directory shall contain the same information the WDS plan staff accesses when assisting members and prospective members inquiring about provider availability.

[18] H&S § 1367.27(e)(1).
[19] H&S § 1367.27(e)(2).
[20] H&S § 1367.27(o)(2)(C).
[21] H&S § 1367.27(c).

a. No Restrictions or Limitations. The Electronic Directory shall be available to the public, potential enrollees, enrollees, and providers without any restrictions or limitations.[22] When accessing the Electronic Directory, there is no requirement to:[23]

i. Demonstrate coverage with the Plan;

ii. Indicate interest in obtaining coverage with the Plan;

iii. Provide a member identification or policy number; or

iv. Create or access an account.

b. Search Functions. The Online Directory allows individuals to search for a provider by each of the Required Fields listed in Section 4 below.[24] When searching by a zip code, individuals may narrow the results to a 10, 20, 30, 40, 50, or 100 mile radius.

c. Updated Weekly. The Online Directory is updated at least weekly and when the Plan is informed of changes, including upon confirmation that a Provider's practice location or other information has changed.

3. **Print Directory.** Upon request, WDS shall provide enrollees, potential enrollees, providers, and members of the public with a printed or emailed version of the Provider Directory. Printed provider directories shall be updated every quarter.

a. Requests: Requests can be submitted by:

i. **Phone:** 1-800-992-3366;

ii. **Mail:** 530 South Main Street, Orange, California 92868; or

iii. **E-mail:** customerservice@westerndental.com.

b. Geographic Specificity: Printed Directories may be limited to the geographic region in which the requester resides, works, or intends to reside or work.

c. Timing: A printed copy of the provider directory will be mailed to the requestor, postmarked no later than five (5) business days following the date of request.[25]

4. **Directory Content.** Each provider listing in both the Online and Print Directory shall include the following "Required Information":[26]

a. The provider's name;

b. The practice or office name;

c. Practice location(s), including county, city, state, and zip code;

d. Contact information, including office email address, if available;

e. Type of practitioner;

[22] H&S § 1367.27(c)(1).
[23] H&S § 1367.27(c)(1).
[24] H&S § 1367.27 (c)(2).
[25] H&S § 1367.27(d)(1).
[26] H&S § 1367.27(i).

f. Area of specialty, including board certification or other accreditation, if any;

g. NPI number;

h. California license number;

i. The name of each affiliated provider group or specialty plan practice group currently under contract with the Plan through which the provider sees enrollees;

j. To the extent the Plan has a direct contract for allied health care professional services, the names of each allied health care professional;

k. Non-English language(s), if any, spoken by a health care provider, other medical professional, or qualified medical interpreter on the provider's staff;

l. Whether the provider is no longer accepting new patients for some or all of the Plan's products; and

m. Any hospital privileges.

5. Required Disclosures. Both the Online and Print Directories shall contain the following disclosures:

a. Language Interpreter Service.[27] In accordance with Section 1367.04, the Directory shall inform enrollees that language interpreter services are available at no cost to the enrollee, and how they can obtain interpretation services.

b. Americans with Disabilities Act.[28] The Directory shall inform enrollees that they are entitled to full and equal access to covered services, including enrollees with disabilities as required under the federal American with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

c. Reporting Inaccuracies. Members of the public and providers may notify the Plan of inaccuracies in the Provider Directory by phone, email, or online.[29] Contact information for reporting inaccuracies shall be prominently disclosed in the Provider Directory and on the Plan's website, including a phone number and dedicated email address for receiving reports of inaccuracies.[30]

d. Timely Access to Care. In a separate section titled "Timely Access to Care," the Plan shall include information regarding the standards for timely access to care.[31]

I.J8 – PROVIDER CONTRACTS

1. Required Updates to Provider Information. Contracted providers shall be required to sign a dental provider agreement that requires that the provider inform WDS within five business days when:

a. The provider is not accepting new patients or

b. If the provider had previously not accepted new patients, the provider is currently accepting new patients.

[27] H&S § 1367.27(g)(1).
[28] H&S § 1367.27(g)(2).
[29] H&S § 1367.27(f).
[30] H&S § 1367.27(f).
[31] H&S § 1367.031(d).

2. **Directing Inquiring Patients.** When contacted by an enrollee or potential enrollee seeking to become a new patient, contracting providers are required to direct that person to both WDS for additional assistance in finding a provider and to the Department to report any potential provider directory inaccuracy.

I.J9 – UPDATES TO DMHC

1. **Annual Policy Submission.** On an annual basis, this policy shall be submitted as Exhibit J-14 to the DMHC for approval[32] along with a report of any payments or reimbursements that were delayed by the Plan.[33]

2. **10% Change in Network.** The Plan's Provider Relations staff shall monitor changes to the Directory to determine if there has been a ten percent (10%) or greater change to the provider names listed for a network for a product in that region. Whenever the Plan determines that such a change has occurred, the Plan shall file an amendment with the DMHC.[34]

[32] H&S § 1367.27(m)(1).
[33] H&S § 1367.27(p)(4).
[34] H&S § 1367.27(r).

Western Dental
BENEFITS DIVISION

SAMPLE

XX/XX/XXXX

PROVIDER DIRECTORY UPDATE NOTICE

[Facility#]
[DENTAL OFFICE NAME]
1234 PROVIDER WAY
ORANGE, CA 92868

Dear Doctor [LAST NAME]:

Western Dental is required to display an accurate provider directory for contracted facilities and associate providers to comply with California Senate Bill 137. Please review the information below for accuracy and update appropriately leaving no item blank. Once all information is reviewed and/or updated, please sign the form and fax it to 714-571-3650 or email it to ProviderDirectoryUpdate@westerndental.com.

Please respond by XX/XX/XXXX

Failure to respond may result in a delay of provider's claim reimbursement.

Please review the information below and make any necessary corrections.

	Current Facility Information	**New/Revised Information; if applicable**
Practice Phone Number	*[OFFICE PHONE NUMBER]*	
Practice Email Address	*[EMAIL ADDRESS]*	
Office Hours	Mon 09:00AM - 06:00PM Tue 08:00AM - 05:00PM Wed 09:00AM - 06:00PM Thu 09:00AM - 06:00PM Fri 08:00AM - 04:00PM Sat - CLOSED Sun - CLOSED	
Languages Spoken	SPANISH, TAGALOG, ENGLISH	
Facility Street Address	*[STREET ADDRESS]*	

Western Dental®
BENEFITS DIVISION

Please provide a list of any associate(s) at this location currently not listed above, if necessary attach a separate list.

	Current Associate Information Below	**Indicate Yes or No that Associate is still affiliated with this facility**
Associate Name	LASKA, MARK SROL, DDS	
Associate License Number	*********	
Associate NPI Number	*********	
Specialty Type	General	
Board Certification	***	

Our records indicate that your facility is currently OPEN to enrollment for the following Benefit Plans:

750
750+
7700
7705
7710
7720
7730
7740
7750
7760

YES, I confirm the above information is accurate. INITIAL _____

NO, The above information is incorrect, see corrections below:

_____

_____ INITIAL _____

Attestation:
By signing this form you're acknowledging you have reviewed the above information and have made any appropriate changes.

_____ _____ _____

Name of Owner Dentist or Authorized Person Signature Date

Western Dental®
BENEFITS DIVISION

Please return this entire form including the signature page to Western Dental either by fax or email. If you have questions regarding the credentialing of new associates please call us at 800-811-5111.

Scan and email to: ProviderDirectoryUpdate@westerndental.com
Or Fax to: Western Dental Provider Relations: 714-571-3650

Sincerely,

Provider Relations
Western Dental Services

Western® Dental
BENEFITS DIVISION

SAMPLE

SECOND NOTICE

XX/XX/XXXX

Dear Provider:

Western Dental Services, Inc., recently notified you of the recent state requirements to provide timely corrections regarding updates to your dental office and any associate doctors. As of today, we have not received your response.

Please note your submission needs to be received within fifteen (15) business days of the date of this letter. Should you have any questions please feel free to contact our Providers Relations Department at 1-800-811-5111.

Sincerely,

Provider Relations
Western Dental Services

Western® Dental
BENEFITS DIVISION

SAMPLE
FINAL NOTICE

XX/XX/XXXX

Dear Provider:

Western Dental Services, Inc., recently notified you on **(insert date)** of the recent state requirements to provide timely corrections regarding updates to your dental office and any associate doctors. As of today, we have not received your response.

Please note your dental office information will be removed from our provider directory on **(insert date)**. Should you have any questions please feel free to contact our Providers Relations Department at 1-800-811-5111.

Sincerely,

Provider Relations Department
Western Dental Services

How To Report a Provider Directory Inaccuracy

In an effort to comply with State requirements for providing an accurate provider directory, Western Dental Services now offers several easy ways to report a potential provider directory inaccuracy. The regulation requires WDS to verify and confirm with all contracted providers that their information is current and up to date. Notifications will be sent to all contracted providers every six months and will require an affirmative response within 30 days acknowledging the notification was received and information about any applicable changes to the data on file. To report any provider directory inaccuracies contact Provider Relations at **1-800-811-5111**, via email at ProviderDirectoryUpdate@westerndental.com or by using the online change form available by clicking the ***Provider Update*** link on our website, http://www.westerndentalbenefits.com.

XIII.

LANGUAGE ASSISTANCE PROGRAM

“LAP”

LANGUAGE ASSISTANCE PROGRAM

The following section contain important information about how to assist a WDS member with limited English proficiency through the use of language interpreter services.

Language Assistance Program
PROTOCOL

1. **What is the Language Assistance Program (LAP)?**

   The Language Assistance Program is required by law and regulated by the California Department of Managed Health care (DMHC). The program is available to Limited English Proficient plan members to ensure access to services in their preferred spoken and written language. We are required to provide this service at no cost to the plan member. Western Dental Services (WDS) maintains a member Language Assistance Program (LAP) to assist Limited English Proficient (LEP) members to communicate easily with their dental provider. If you have a non-English speaking Western Dental Services member assigned to your office, you should call the WDS Plan Member Services Department at 1-800-992-3366.

2. **LAP ongoing monitoring and compliance requirements**

   a. WDS monitors compliance on a quarterly basis through random "secret shopper" calls to contracted IPA providers in the Plan's network.
   b. Offices that fail to successfully assist a Limited English Proficient caller are subject to the following corrective actions:
      - First quarter non-compliant office receives counseling and is provided additional training on LAP protocol.
      - Second consecutive quarter non-compliant office receives counseling, office receives additional training and is given a verbal warning.
      - Third consecutive quarter non-complaint office receives all the above and any further necessary corrective action(s) as determined by the Plan's Utilization Management committee, which could include closing the office to new members and/or transferring assigned plan members to another office.
   c. It is the policy of WDS to monitor ongoing compliance with the program to ensure appropriate access to services for Limited English Proficient plan members as required by regulation.

3. **LAP Protocol for California Provider offices**

   a. When patient/member **calls the office** and needs LAP services and is speaking in another language not spoken by the office:

      - Office determines LAP is needed due to inability to communicate or member requests LAP services.
      - Provider office initiates a 3 way call to the WDS Member Services Department at 1-800-992-3366.

- The WDS Member Service Department contacts the LAP vendor (translation service) and translation service is provided to the member via telephone.
- Future LAP Assistance, including telephonic or face to face translation may be deemed necessary for future appointments.

b. When patient is **at the office** and needs LAP services:

- Office determines the LAP is needed due to inability to communicate or member requests LAP services.
- Office calls WDS Member Services Department at 1-800-992-3366 informing them that they have a member in the office that needs LAP assistance.
- WDS Member Service Department places office on hold and coordinates the 3 way call with the LAP vendor (translation service) and translation service is provided to the member via telephone.

4. Things to remember when assisting a member/patient that is Limited English Proficient

a. **DO NOT HANG UP** on **any** caller because you don't understand their language.
b. If anyone calls in a foreign language always assume the caller qualifies for LAP.
c. If they identify themselves with "Western Dental" or "Language Assistance" follow protocol above.
d. Handle the LAP caller with respect and patience.

WESTERN DENTAL SERVICES, INC. QUALITY MANAGEMENT POLICIES AND PROCEDURES	
SECTION I – ACCESS AND AVAILABILITY	
I.H – Language Assistance Program	
UM Chair:	Approved on:
QIC Chair:	Approved on:

I.H1 – POLICY REGARDING LANGUAGE ASSISTANCE PROGRAM

It is the policy of Western Dental Services, Inc., ("WDS") to provide free (no cost) interpretation services to all enrollees who are limited English proficient ("LEP") and request the services of an interpreter. An enrollee who is LEP is an individual who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with the WDS dentist or WDS non-dentist employees.

In addition to interpretation services, WDS will translate written vital documents into its established threshold language(s), as determined by a periodic enrollee survey and other statistical methodologies. "Threshold" languages are the languages identified by WDS pursuant to Section 1367.04(b)(1)(A) of the Knox-Keene Act, which will include the top language other than English, and any additional languages, when 1% or 6000 enrollees, whichever is less, indicate a preference for materials in that language.

WDS identifies the following plan vital documents that will be translated into threshold languages, as defined in the Knox-Keene Act and any regulations promulgated thereunder:

- Enrollment Form or "WDS Enrollee Applications"
- Member Identification Card (including Emergency Services information)
- HIPAA Privacy Notice
- Letters to enrollees containing eligibility and participation criteria or status
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Any notices that may from time to time be published by WDS notifying LEP enrollees of the availability of free language assistance
- Certain outreach materials related to the WDS Language Assistance Program ("LAP")
- Explanation of Benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee notifying an enrollee of a denial, reduction, modification or termination of services or benefits, including the right to file a grievance or appeal
- A summary matrix of covered services, copayments and coinsurance and exclusions and limitations as per Section 1363(b)(1) of the Knox-Keene Act.
- WDS Grievance Form

It is the policy of WDS to provide training to WDS staff and contracted providers in the requirements of the LAP.

It is the policy of WDS to monitor the LAP and make modifications as necessary to ensure continued compliance with LAP regulatory requirements as stated in Section 1367.04 of the Knox-Keene Act, and any regulations promulgated thereunder.

PROVIDER BULLETIN

Language Assistance Program (LAP)

Western Dental maintains a member Language Assistance Program (LAP) to assist Limited English Proficient (LEP) members to communicate easily with their dental provider. If you have a non-English speaking member assigned to your office, you can request interpreter services from Western Dental. There is never a charge to your office or the patient for these services.

To arrange for interpreter services, please call Western Dental's Member Service Department at **1-800-992-3366** and request the appropriate language. Interpreter services are available over the telephone or in person. Please note that in person interpreters typically require 72 hours' notice.

Western Dental may verify your office's competency in this program through secret shopper calls or during on-site audits. It is important that your staff be familiar with the Western Dental LAP and how to request interpreter services. If you have any questions about Western Dental's LAP, please contact Provider Relations at **1-800-811-5111.**

Thank you for your participation in our network!

Western® Dental
SERVICES, INC.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

To Our Non-English Speaking Members – About Interpreters:

Many people who live in California speak a language other than English. Even if they know some English they may prefer to discuss dental health issues or dental plan benefits in another language. Western Dental wants to make it easy for members to talk to the dentist and ask questions. We have many services to help you in your preferred language.

Three Ways to Help You: Western Dental can help you with:

- Bi-lingual staff: Many people who work in the office speak a language other than English. You can ask if there is someone who speaks your language.
- Interpreters on the phone: Any Western Dental dentist can call and get an interpreter on the phone, 24 hours a day, 7 days a week. You will never be charged for this service.
- Face-to-face interpreters: A face-to-face interpreter may be available if you need special instructions in a language other than English, including Sign Language. You will never be charged for this service.

To get help with any of these services, call your dental office or call Western Dental's Customer Service Department at 1-800-992-3366. It may take 24 to 48 hours to arrange for face-to-face interpreters.

About Important Papers:

Western Dental may be able to provide you with vital documents, forms, and outreach materials in certain widely spoken "threshold" languages. These include:

- Plan Summaries and Brochures – (Evidence of Coverage)
- Provider Directories and appointment information
- Important forms and letters about dental services and dental plan benefits including notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Your language service rights

You can call Western Dental's Customer Service Department to find out if these papers are available in your preferred language. If you have questions or need help, call Western Dental's Customer Service Department at 1-800-992-3366.

Western Dental Speaks Your Language

Western® Dental
SERVICES, INC.

AVISO DE DISPONIBILIDAD DE SERVICIOS DE AYUDA DE IDIOMAS

A Nuestros Miembros que No Hablan Inglés – Sobre los Intérpretes:

Muchas personas que viven en California hablan un idioma distinto al inglés. Incluso si ellos saben inglés, es posible que prefieran hablar sobre asuntos de salud dental o de los beneficios del plan dental en otro idioma. Western Dental desea que los miembros puedan comunicarse fácilmente con el dentista y hacerle preguntas. Tenemos muchos servicios para ayudarle en su idioma preferido.

Tres Formas de Ayudarle: Western Dental le puede ayudar con:

- Personal bilingüe: Muchas personas que trabajan en la oficina hablan un idioma distinto al inglés. Usted puede preguntar si hay alguien que hable su idioma.
- Intérpretes por teléfono: Cualquier dentista de Western Dental puede llamar y conseguir un intérprete por teléfono, las 24 horas del día, los 7 días de la semana. A usted nunca se le cobrará por este servicio.
- Intérpretes en persona: Es posible que se encuentre disponible un intérprete en persona si usted necesita instrucciones especiales en un idioma que no sea inglés, incluyendo lenguaje por señas. A usted nunca se le cobrará por este servicio.

Para obtener ayuda con cualquiera de estos servicios, llame a su oficina dental o llame al Departamento de Servicio al Cliente de Western Dental al 1-800-992-3366. Es posible que tome entre 24 a 48 horas hacer los arreglos para intérpretes en persona.

Acerca de Documentos Importantes:

Western Dental tal vez pueda proveerle documentos esenciales, formularios y materiales de alcance en algunos idiomas populares "sobre el límite". Estos incluyen:

- Resúmenes del Plan y Folletos - (Evidencia de Cobertura)
- Directorios de proveedores e información de citas
- Formularios y cartas importantes sobre los servicios dentales y beneficios del plan dental, incluyendo avisos relacionados con negaciones, reducciones, modificaciones o término de los servicios y beneficios, y el derecho a presentar una queja o apelación.
- Sus derechos de servicio de idioma

Usted puede llamar al Departamento de Servicios al Cliente de Western Dental para averiguar si estos papeles están disponibles en su idioma preferido. Si tiene preguntas o necesita ayuda, llame al Departamento de Servicio al Cliente de Western Dental al 1-800-992-3366.

Western Dental Habla Su Idioma

XIV.

ANTIFRAUD PLAN

Western Dental's Antifraud Plan

Western Dental
Antifraud Plan

1. MISSION STATEMENT

Western Dental Services, Inc. and all of its affiliates and subsidiaries (collectively "Western Dental") are committed to serving the dental care needs of the public in all communities at affordable prices, with skilled and compassionate doctors and employees, state of the art equipment and facilities, and excellent quality management oversight; working with dental schools and other institutions to improve dentistry; and increasing public awareness of the importance of dental care. In furtherance of its Mission Statement, Western Dental has established an Antifraud Program.

2. PURPOSE OF ANTIFRAUD PROGRAM

Western Dental is committed to conducting business activities in compliance with all applicable rules, laws and regulations. Western Dental's Board of Directors, executives, management, employees and independent contractors (collectively "personnel") are dedicated to high ethical standards and recognize their duty to conduct all business within the bounds of the law. Western Dental strives to promote a corporate culture of integrity.

For the purpose of this Antifraud Plan, "fraud" is defined to include, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. The purpose of the Antifraud Program shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.

The Antifraud Program shall include, but not be limited to, all of the following:

- the designation of an Antifraud Committee and Antifraud Officer to investigate and manage incidents of suspected fraud;
- the training of Western Dental personnel concerning the detection and prevention of health care fraud; and
- the implementation of procedures for reporting suspected fraud to the Antifraud Officer or Antifraud Committee, and for referring suspected fraud to the appropriate government agency.

3. THE ANTIFRAUD PROGRAM AND CODE OF ETHICS

A. Designation of the Antifraud Officer

The Board of Directors of Western Dental shall appoint an Antifraud Officer. The Antifraud Officer shall be responsible for overseeing and enforcing all aspects of the Antifraud Program. The Antifraud Officer shall work with Western Dental's General Counsel and outside legal counsel ("Counsel") as set forth in this Program.

The identity of the Antifraud Officer shall be disseminated to all employees in conjunction with the dissemination of the Antifraud Program.

The duties of the Antifraud Officer shall include:

(i) knowing and understanding the Antifraud Program;

(ii) participating in training and continuing education regarding current Antifraud laws and regulations;

(iii) bringing to the attention of the Board of Directors and/or the General Counsel all changes and circumstances which could reasonably suggest that the Program should be modified;

(iv) reporting periodically to the Board of Directors regarding the operation of the Program and relevant significant developments;

(v) maintaining a file of any documented report or complaint of fraud;

(vi) investigating or assisting in the investigation of any reported incident of fraud; and

(vii) where appropriate, preparing a recommendation for corrective action, including, but not limited to:

- Returning improperly received payments;
- Disciplinary action against personnel involved with obtaining improper payments;
- Filing appropriate reports -- Section 805, National Practitioner Data Bank, and any other appropriate remedial measures (*e.g.*, educational activities, or additional investigations if it appears there may be a pattern of fraud);

(viii) consulting with Counsel regarding the suspected fraud, and, where appropriate, notifying government agencies (both Federal and State);

(ix) formally notifying the Board of Directors and the CEO of the incident and the planned response; and

(x) preparing an annual written report to the California Department of Managed Health Care and any other authority requiring an antifraud report describing Western Dental's efforts to deter, detect and investigate fraud and to report cases of fraud to appropriate law enforcement.

Ruthie Romano is Western Dental's Vice President of Quality Management. Ms. Romano can be reached at the Western Dental Corporate office at (714) 571-3601.

B. Antifraud Committee

The Board of Directors shall appoint, and the Antifraud Officer shall work closely with, an Antifraud Committee of with a minimum of three (3) and a maximum of seven (7) members. While the identity of the individuals comprising the Committee may vary, the members shall include at least two officers of Western Dental.

The Antifraud Committee shall assess the existing Western Dental policies and procedures. The Committee shall, in coordination with the Antifraud Officer, develop those policies and procedures that will constitute the Antifraud Program. The Antifraud Officer and the Antifraud Committee will continuously review and revise the Program in order to address any changes in applicable laws or regulations and Western Dental activities that require the establishment of additional or revised policies and procedures.

The Antifraud Committee shall also monitor the development of internal systems and controls to carry out Western Dental's standards, policies and procedures as part of its daily operations. The Antifraud Committee shall determine appropriate strategies to promote compliance and to detect potential violations of the Antifraud Program.

The Antifraud Committee shall meet as necessary, but not less than once a year.

C. Policies and Procedures Regarding Detecting Fraud

i. Internal Procedures and Safeguards to Detect Fraudulent Activities

Western Dental utilizes a number of its departments to assist the detection of, as well as the investigation and reporting of suspected fraud to the appropriate government agency, including but not limited to: The Quality Management Department, the Internal Audit Department, the Legal Department, the Billing Department, the Operations

Management (including Clinical Directors and Operations Directors), and Human Resources.

The Quality Management Department

The Quality Management ("QM") Department, under the direction of the Chief Dental Director, is charged with the responsibility for developing and enforcing Western Dental's dental policies and procedures. The QM Department staff includes dentists, specialists, a statistician and other non-dental staff, who may identify fraudulent practices at Western Dental's staff model offices and among its independent practice association ("IPA") providers. The QM Department utilizes the "CADP101" audit instrument and other instruments, tools and criteria that may uncover potentially fraudulent activity in violation of Western Dental's practices and policies. Discoveries of potentially fraudulent activity are to be reported by the QM Department to the Antifraud Officer and/or the General Counsel.

Internal Audit Department Auditors

Western Dental's Internal Audit Department has the function of auditing the Western Dental staff model offices to ensure compliance with Western Dental's procedures and practices relating to billing and administration. Discoveries of potentially fraudulent activity are to be reported by the Internal Audit Department to the Antifraud Officer and/or the General Counsel.

Operations Management: Operations Directors/Clinical Directors

It is the role of Western Dental's Operations Directors to oversee, train and survey the non-doctor employees at Western Dental's staff model offices. Operations Directors are assigned a number of offices; the Operations Directors visit/inspect a staff model office to which they are assigned approximately twice each month. While visiting the staff model offices, Operations Directors are responsible for reviewing compliance with Western Dental's practices and procedures, including fraud prevention and detection.

In addition to Operations Directors, Western Dental utilizes a team of Clinical Directors to audit the dental operations of the staff model offices. Clinical Directors are responsible for ensuring compliance with Western Dental's practices and procedures, including fraud prevention and detection.

Western Dental's Operational Management is to report incidents of potentially fraudulent activity to the Antifraud Committee and/or the General Counsel.

Credentialing Staff

Western Dental's Credentialing staff runs queries with the National Practitioners Data Bank, HealthCare Integrity and Protection Data Bank and Office of the Inspector General to identify doctors with history of fraudulent actions. The credentialing queries are completed for all of Western Dental's newly hired doctors and newly contracted IPA providers, and every three years thereafter.

Billing Department

The Billing Department interacts regularly with the Western Dental staff model offices regarding issues related to accuracy in billing practices and compliance with Western Dental's practices and procedures. Any issues of fraud are to be reported to the Antifraud Committee and/or the General Counsel.

Training Department

As revisions are made, the revised Antifraud training will continue to be distributed to Western Dental personnel by the Training Department in accordance with the Plan's guidelines, and filed with the Department of Managed Health Care as appropriate.

ii. Code of Conduct Regarding Reporting Fraudulent Activities

In addition to the reporting and detection mechanisms outlined above, Western Dental personnel shall maintain individual responsibility for monitoring and reporting any activity that appears to have violated any applicable laws, rules, regulations, or the Code of Conduct set forth below.

Western Dental personnel will strive to ensure all activity by or on behalf of Western Dental is in compliance with applicable laws, regulations, and accreditation standards. This includes, but is not limited to, the False Claims Acts (under both Federal and State law), which places a duty on everyone at Western Dental to prevent and report fraud, waste and abuse of taxpayer dollars associated with billing fraud associated with the Denti-Cal program.

The standards set forth below are designed to provide guidance to ensure that Western Dental's business activities reflect the highest standards of business ethics and integrity. Conduct not specifically addressed must be consistent with the above-stated principle.

Honest Communication

Western Dental requires candor and honesty from Western Dental personnel in performance of their responsibilities. No Western Dental personnel shall make false or

misleading statements to any patient, enrollee or other person, or entity doing business with Western Dental, or about products or services of Western Dental or its competitors.

In furtherance of Western Dental's commitment to the highest standards of business ethics and integrity, Western Dental's personnel will accurately and honestly represent Western Dental and will not engage in any activity or scheme intended to defraud anyone of money, property or honest services. In addition, clinical decisions will be based on identified patient health care needs.

Fraud and Abuse

Western Dental expects its personnel to refrain from conduct that may violate the fraud and abuse laws. Prohibited conduct includes, but is not limited to: (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payer, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; (3) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service; and (4) making claims for items or services which are not medically necessary.

Billing and Coding

Western Dental will not tolerate false statements by any Western Dental personnel regarding billing. Deliberate misstatements to government agencies or other payers may expose the Western Dental personnel involved to disciplinary action, and civil or criminal penalties.

(a) Billing for Services. In providing healthcare services, Western Dental bills the patient, an insurance company, and/or the government pursuant to a number of government sponsored benefit programs. Insurance companies, as well as the government, have strict billing requirements that require our billing claims to be honest, accurate, complete and fully comply with the law. Western Dental is committed to full compliance with all rules and regulations of Denti-Cal and other Federal and State health care programs, as well as the requirements of commercial insurance programs.

All claims must accurately reflect the documented services provided, and only services that have accurate and adequate supporting documentation in the patient's medical record are billed. Late entries or marginal notes in a medical record must be noted or explained. Western Dental personnel will apply the correct coding principles and guidelines when analyzing medical records documentation. Appropriate documentation will be maintained prior to billing and will be available for audit if necessary.

It is against Western Dental's policy to:

(i) Bill for items and services that were not ordered and not performed;

(ii) Bill for items and services that are not medically necessary for the diagnosis or treatment of a patient, or are not appropriate as supported by the conditions of the patient;

(iii) Unbundle or fragment services;

(iv) Misuse procedure codes or miscellaneous diagnosis codes;

(v) Upcode (selecting a code to maximize reimbursement when such code is not the most appropriate descriptor of the service provided); and

(vi) Fabricate diagnostic information, use computer programs that automatically insert diagnostic information, or use diagnostic information from earlier dates of service.

(b) **Subcontracts for Billing**. Subcontractors or independent contractors hired by Western Dental may become agents for Western Dental and act on behalf of Western Dental while performing their duties. These individuals and entities must adhere to the same billing and coding standards applicable to all other Western Dental personnel. Moreover, any incentive arrangements for subcontractors to "maximize reimbursement" are expressly prohibited.

Marketing and Advertising

Western Dental may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and to recruit Western Dental personnel. Marketing materials shall truthfully represent the availability of services, the level of licensure, certification and accreditation, and affiliation with other providers, educational institutions and payers. Marketing materials include advertising copy, promotional literature, patient solicitation guides, referral development or networking guides, and selling aids of any type. Western Dental does not use advertisements or marketing programs that might cause confusion between our services and those of our competitors.

D. Reporting Suspected Fraudulent Activities

In order to provide Western Dental employees with every avenue possible in which to raise their concerns regarding suspected fraudulent activity in violation of the Western Dental Code of Ethics, Western Dental has established a reporting mechanism that includes anonymous reporting if the person making the report so desires. Anyone

aware of a violation of the Antifraud Program shall report the improper conduct to the Antifraud Officer and/or the toll-free antifraud hotline at **(855) 203-6016**. The Antifraud Officer, in conjunction with the General Counsel, shall investigate all reports and ensure that the proper follow-up actions are taken, including making a report to the appropriate government agency.

Additional Telephone Numbers For Reporting Suspected Incidents of Fraud

Antifraud Officer	(800) 417-4444 extension 13601
General Counsel	(800) 417-4444 extension 13695
Director of Human Resources	(800) 417-4444 extension 13416

Western Dental prohibits any retaliation against anyone who makes a report of fraud in good faith. The law protects individuals who file "whistleblower" lawsuits in good faith. No employee shall be punished on the basis that he/she reported what he/she reasonably believed to be an act of wrongdoing or a violation of this Antifraud Program. However, an employee may be subject to disciplinary action if Western Dental reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect or benefit the reporting employee.

Known violations of the Antifraud Program, including an employee's failure to report a suspected incident of fraud, shall be treated at least as seriously as any other employment transgression, and may result in dismissal if such action is determined appropriate by Western Dental. Violations of standards and principles or not reporting a violation will not be tolerated, and may result in the imposition of one or more of the following sanctions, as deemed appropriate:

(i) Verbal warning;

(ii) Written warning with copy in the Human Resources personnel file;

(iii) Suspension without pay;

(iv) Termination;

(v) Reimbursement of losses or damages; and

(vi) Referral for criminal prosecution or civil action.

Determinations as to appropriate discipline will be made on a case-by-case basis. Sanctions imposed will reflect the seriousness of the offense and any unique circumstances of the situation. A record of any discipline accorded to a Western Dental employee as a result of noncompliance with the Antifraud Program shall be maintained in the Western Dental employee's personnel record.

In addition to the disciplinary action that may be imposed by Western Dental, causing or allowing fraud to take place at Western Dental (including the failure to report suspected fraud as outlined above) could expose both Western Dental and the individuals involved to Federal or State criminal prosecution, Federal or State civil actions and other Federal administrative civil penalties.

E. Training and Education of Western Dental Personnel

All Western Dental personnel will receive and review the Antifraud Handbook/Training within two weeks of beginning employment with Western Dental. An annual Antifraud Training (which includes information regarding the Federal and applicable State False Claims Acts) will be conducted and logged by the Western Dental Training Department for personnel involved with billing activities.

F. Federal False Claims Act

The Federal False Claims Act prohibits any person from knowingly submitting or causing the submission of a false or fraudulent claim for payment to the federal government.

1. Definitions:
   a. "Knowing" or "knowingly" shall mean that a person, with respect to information:
      - Has actual knowledge of the information;
      - Acts in deliberate ignorance of the truth or falsity of the information; or
      - Acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

   b. "Claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

2. Penalties and Remedies

   a. The civil penalty for each false claim is not less than $5,000 and not more than $10,000, plus three times the amount of actual damages suffered by the federal government. 31 U.S.C.S. § 3729(a).

b. 31 U.S.C.S. §§ 3801-3808 include detailed information about the administrative process involved in the Federal False Claims Act including definitions of individuals, positions and events that occur from a false claim or statement through the investigation, hearings and judicial review.

3. Whistleblower Protections: 31 U.S.C.S. § 3730(h) protects employees against discharge, demotion, suspension, threats, harassment, or discrimination by the employer because of lawful acts done by the employee in cooperating with the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the Act.

G. California False Claims Act

Pursuant to the California False Claims Act, a person violates the Act if he/she does any of the following:

a. Knowingly presents or causes to be presented to an officer or employee of the state or of any political subdivision thereof, a false claim for payment or approval.

b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false claim paid or approved by the state or by any political subdivision.

c. Conspires to defraud the state or any political subdivision by getting a false claim allowed or paid by the state or by any political subdivision.

d. Has possession, custody, or control of public property or money used or to be used by the state or by any political subdivision and knowingly delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt.

e. Is authorized to make or deliver a document certifying receipt of property used or to be used by the state or by any political subdivision and knowingly makes or delivers a receipt that falsely represents the property used or to be used.

f. Knowingly buys, or receives as a pledge of an obligation or debt, public property from any person who lawfully may not sell or pledge the property.

g. Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state or to any political subdivision.

h. Is a beneficiary of an inadvertent submission of a false claim to the state or a political subdivision, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state or the political subdivision within a reasonable time after discovery of the false claim.

1. Definitions:

a. "Claim" includes any request or demand for money, property, or services made to any employee, officer, or agent of the state or of any political subdivision, or to any contractor, grantee, or other recipient, whether under contract or not, if any portion of the money, property, or services requested or demanded issued from, or was provided by, the state or by any political subdivision thereof.

b. "Knowing" and "knowingly" shall mean that a person, with respect to information, does any of the following:

- Has actual knowledge of the information.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information and proof of specific intent to defraud is not required.

c. "Person" includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business, or trust.

2. Penalties and Remedies

a. Any person who submits a false claim shall be liable for three times the amount of damages sustained by the state and costs of a civil action brought to recover any such penalties. Any such person may also be liable for a civil penalty of not less than $5,000 and not more than $10,000 for each false claim. Cal. Govt. Code § 12651.

b. Any person who submits a false claim may also be subject to imprisonment in the county jail for a period of not more than one year, a fine of not exceeding one $1,000, or by both such imprisonment and fine, or by imprisonment in the state prison, by a fine of not exceeding $10,000, or by both such imprisonment and fine. Cal. Pen. Code § 72.

3. Whistleblower Protections:

a. California Government Code Section 12653 provides protection for employees by preventing employers from making, adopting, enforcing any rule, regulation or policy that would prevent an employee from disclosing information to a

government or law enforcement agency or from acting in furtherance of a false claims action.

b. California Government Code Section 12653 also provides that no employer shall discharge, demote, suspend, threaten, harass, deny promotion to, or in any other manner discriminate against, an employee in the terms and conditions of employment because of lawful acts done by the employee on behalf of the employee or others in disclosing information to a government or law enforcement agency or in furthering a false claims action, including investigation for, initiation of, testimony for, or assistance in, an action filed or to be filed under the California False Claims Act.

XV.
CORRESPONDENCE

Provider Newsletter

Fall/Winter 2024

WD PLAN
GROUP AND INDIVIDUAL

Oral Cancer Screening (OCS): Early Detection Saves Lives

Oral cancer is a growing concern, with over 54,000 new cases of oral and oropharyngeal cancer diagnosed annually in the United States. Despite advances in treatment, survival rates remain significantly lower when cancers are discovered in later stages—underscoring the critical role of routine screening and early detection.

Why It Matters
Oral cancers often present without pain in the early stages and may go unnoticed by patients. Unfortunately, many are diagnosed only when the disease has advanced, contributing to a five-year survival rate of around 40–50%. When detected early, this number improves to over 80%, making regular screening a lifesaving intervention.

Who Should Be Screened?
The American Dental Association recommends that all adults, particularly those over age 18, be screened for signs of oral cancer during routine dental exams. Individuals with risk factors—such as tobacco and alcohol use, HPV infection, or prolonged sun exposure—are at even greater risk and should be monitored closely.

What to Look For
Providers should conduct a systematic visual and tactile examination, including:

- Ulcers or red/white patches that do not heal within two weeks
- Lumps or thickening in the cheek, tongue, or floor of the mouth
- Persistent sore throat or hoarseness
- Difficulty swallowing
- Unexplained weight loss or persistent lymphadenopathy

Adjunctive screening tools (e.g., light-based detection or brush biopsies) may be considered when clinical suspicion is high, including a referral to a specialist.

Take Action
Early diagnosis begins with vigilance. Incorporate oral cancer screening into every patient visit, document findings thoroughly, and refer promptly for biopsy or specialist evaluation when needed. Educating patients about symptoms and risks can also empower them to seek timely care.

By staying alert and consistent with screening protocols, providers can make a measurable difference in patient outcomes—and potentially save lives.

Inside This Issue

Public Policy

The Plan welcomes Provider participation on its Public Policy Committee, which meets quarterly at the Plan's corporate office in Orange, California. In order to be considered for membership, please write or call the Plan's Provider Relations Department at 1-800-811-51

Provider Dispute Resolution Process

As previously notified, providers have the right to utilize the WDS provider dispute resolution process, which was developed to provide a fast, fair and cost-effective dispute resolution mechanism. WDS will not discriminate or retaliate against a provider (including, but not limited to, the cancellation of the provider's contract) because the provider filed a provider dispute. The provider dispute process is available at no cost to the provider.

For additional information regarding the provider dispute process, please contact the Provider Relations Department at 1-800-811-5111.

Disclosure of Review Processes

Upon request, the WDS Member Services department will send you a copy of the guidelines and criteria that are used to determine if a service is covered or not when a dentist or WDS provider sends requests to WDS for benefits and/or claims for payment to an enrollee, a dentist or a member of the general public. You may ask for this information by writing to Western Dental Services, Inc., P.O. Box 14227, Orange, CA 92863, or by calling WDS Member Services at 1-800-992-3366.

Credentials

To ensure that your credentials are always current, don't forget to submit your renewed credentials to WDS **prior** to the expiration of the previous credentials. WDS must maintain copies of your current, valid California dental license, malpractice insurance cover page and DEA certificate in your provider file. Also, please remember to notify WDS Provider Relations whenever your office has a new associate dentist or dental specialist or when there are changes or updates to your credentials.

Reminder, please respond to the California Senate Bill 137 mailers sent to the office to confirm that the information we currently have in our provider directory is correct and up to date.

Encounter Data Submission

The California Knox-Keene Act requires all Dental HMOs to monitor plan enrollee utilization. The WDS Utilization Management (UM) Committee meets on a quarterly basis to review utilization trends to ensure that Plan enrollees are receiving ser- vices. WDS also uses the utilization data to develop new plans and re- view existing provider compensation for the managed care dental pro- gram.

Please submit your encounter data by the 10th day of the month for the previous month's encounters. To submit monthly encounter data, please use a standard ADA claim form.

New Policy: Encouraging Nonpharmacological Treatments

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Provider Newsletter

Spring/Summer 2024

Periodontal Disease Screening

Periodontal disease affects nearly half of U.S. adults over age 30 and is a leading cause of tooth loss. It's also linked to systemic conditions such as diabetes, heart disease, and adverse pregnancy outcomes. Despite its prevalence, it often goes undetected until advanced stages. Periodontal Disease Screening is a process to identify and determine the health of the existing gums and supporting structures around the teeth. This procedure will aid in early detection and prevention of gum disease and assist in periodontal treatment planning.

Why Screen?

Early detection helps prevent progression and supports overall health. The American Academy of Periodontology recommends routine screening for all adult patients—especially those with chronic conditions, tobacco use, or signs of inflammation.

What to Do

- Perform a periodontal exam at every recall and new patient visit
- Probe for pocket depths and bleeding
- Use sufficient diagnostic radiographs to assess bone loss
- Document findings and treatment plan accordingly

Routine periodontal screening is quick, effective, and essential to comprehensive patient care. Early action helps preserve both oral and systemic health.

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Provider Newsletter

Fall/Winter 2025

WD PLAN
GROUP AND INDIVIDUAL

Manual vs. Electric Toothbrushes: What Should Patients Know?

Helping Patients Make the Right Choice
Patients often ask whether electric toothbrushes are better than manual ones. Here's what to share with them:

Electric Toothbrush Benefits:

- Removes more plaque for some users
- Built-in timers encourage 2-minute brushing
- Great for patients with braces, arthritis, or limited dexterity
- Pressure sensors help prevent gum damage

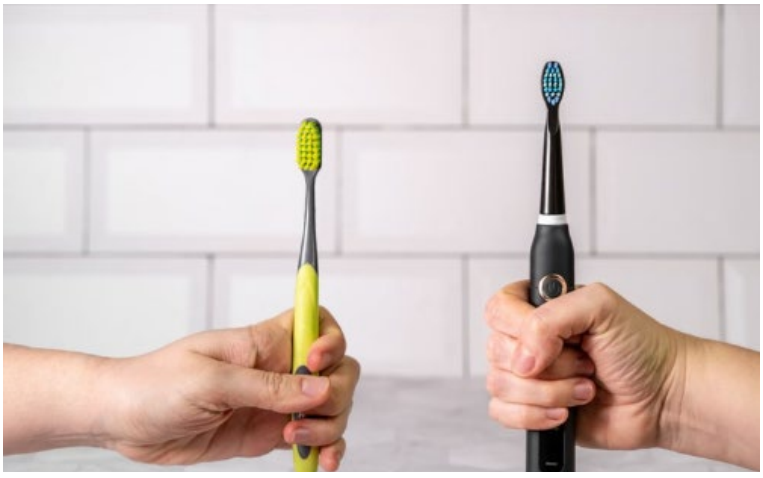
Manual Toothbrush Benefits:

- Affordable and widely available
- Easy for travel or quick use
- Just as effective when used with proper technique

Regardless of type, recommend:

- Brushing 2x daily for 2 minutes
- Using a soft-bristled brush
- Age- appropriate size toothbrush
- Replacing every 3–4 months

Encourage patients to choose the brush they're most likely to use correctly and consistently.



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Provider Newsletter

Spring/Summer 2025

WD PLAN GROUP AND INDIVIDUAL

Diagnosing and Supporting D4346: Scaling in Presence of Inflammation

Procedure D4346 is used for scaling in the presence of generalized moderate or severe gingival inflammation—without attachment or bone loss. It bridges the gap between routine prophylaxis (D1110) and periodontal scaling and root planing (D4341/D4342).

When to Use D4346

D4346 may be appropriate when the patient presents with:

- Generalized moderate to severe gingival inflammation (≥30% of teeth)
- No radiographic bone loss
- No clinical attachment loss
- Presence of plaque, calculus, and bleeding on probing

This procedure is typically used for patients who have not been treated regularly, are returning to care, or are transitioning from neglect to preventive maintenance.

Diagnostic Support

To support the use of D4346:

- Document generalized moderate to severe gingival inflammation in the clinical notes
- Record bleeding on probing and plaque levels
- Include periodontal charting showing pocket depths within normal range (≤3mm)
- Take radiographs confirming the absence of bone loss

Clinical and Billing Considerations

- D4346 is therapeutic, not preventive—it requires diagnosis and documentation.
- It can only be used once the oral evaluation has been completed and the need for treatment identified.
- Do not use with D1110, D4341, D4342, or D4355 on the same date of service.

D4346 is the correct code when moderate to severe inflammation is present without periodontal disease. Accurate diagnosis, detailed documentation, and clear communication with patients and insurers are key to appropriate use.

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